THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-

June 5, 2003

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

TRAUMA CENTER SERVICE AGREEMENT FOR FISCAL YEARS 2003-04 AND 2004-05
(All Districts) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of Health Services, or his designee, to sign the form trauma center service agreement, substantially similar to Exhibit I, including Exhibits A through F, following signature by officials of authorized representatives of the ten non-County trauma centers listed in Attachment B effective July 1, 2003 to June 30, 2005, with a signing deadline for each hospital of July 31, 2003, in order to maintain the Los Angeles County Trauma Center System.

2. Approve reimbursement under the trauma center service agreement to non-County trauma centers at the rates set forth in Exhibit B, up to a maximum approximate amount of $14.8 million annually, and periodic lump sum payments up to a maximum amount of approximately $9.09 million, with a total annual amount of approximately $23.89 million for a total two-year agreement obligation of $47.78 million. This amount may be increased by approximately $6.5 million annually through separate Federal matching funds for a maximum total two-year agreement increase of $13 million.

3. Establish the annual trauma fee for the trauma network of thirteen County- approved trauma centers (ten private and three County-operated) at $32,930 per hospital to offset County costs associated with data collection, monitoring, and evaluation.

4. Establish a requirement for all non-County trauma centers, except Childrens Hospital Los Angeles, to participate in the County's base hospital system and approve payment to offset a portion of the expense for base hospital operations at the non-County trauma centers at the rates listed in Exhibit B.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTIONS:

The purpose of this action is to obtain the Board's approval of contracts necessary to administer the Los Angeles County Trauma Center System for Fiscal Years 2003-04 and 2004-05.

The California Code of Regulations, Title 22, provides specific requirements for the care of the critically injured. A local emergency medical services (EMS) agency may implement a trauma care system only if the system meets the minimum standards set forth in these regulations which were recently revised. In order for the trauma system to operate in Los Angeles County, the Board must approve of the ongoing establishment of the system under regulations that were recently revised, with the requirement that each trauma center enter into an agreement with the County local EMS agency to maintain its County designated trauma center status.

On June 20, 2000, the Board approved a one year agreement for FY 2000-01. Since that agreement, seven amendments have been approved extending the agreement, addressing funding, and designating pediatric trauma centers. Amendment No. 7 is slated to expire on June 30, 2003. This three-month extension was approved to ensure the continued provision of trauma center services until the Department could finalize the County trauma system requirements, resolve the trauma system funding issues, and negotiate the trauma center fees, all of which require Board approval.

In the past, each participating trauma center paid the County an annual fee to offset the costs of data collection, monitoring, and evaluation of the trauma system. The annual trauma fee has been established at $32,930 which requires Board approval.

Existing County policy and procedures require timely submission of contracts for Board approval. However, this request for approval of the Trauma Service Hospital Agreement for Fiscal Years 2003-04 and 2004-05 was not scheduled for placement on the Board's agenda prior to its effective date because negotiations were only recently completed, and due to the volume of Board actions required for the end of the Fiscal Year renewals.

FISCAL IMPACT/FINANCING:

For Fiscal Years 2003-04 and 2004-05, the total monetary commitment to private trauma centers is $23.89 million annually. Reimbursement shall be made to non-County trauma centers at the rates listed in Exhibit B up to a maximum approximate amount of $14.8 million annually, and periodic lump sum payments of approximately $9.09 million. This amount may be increased by approximately $6.5 million annually through separate Federal matching funds.

Financing is offset in part by funding available under State law through the Proposition 99/California Health Care for Indigents Program (CHIP) and the Maddy Emergency Medical

Services Fund (SB612) of approximately $5.3 million annually. The remaining financing in the approximate annual amount of $18.59 million will be funded by an allocation of revenue generated by the special tax under Measure B, Preservation of Trauma Centers and Emergency Medical Services; Bioterrorism Response. However, separate Federal matching funds, if approved will reduce this funding from Measure B by approximately $1.13 million annually. Funding is for the period beginning July 1, 2003, through June 30, 2005.

Current agreements provide for an annual amount payable to County by non-County and County operated trauma centers of $32,930 to offset County costs associated with data collection, monitoring, and evaluation. Estimated annual revenue is $428,090 for Fiscal Years 2003-04 and 2004-05.

Since the negotiations with non-County trauma centers did not conclude until after the final changes deadline for the Fiscal Year 2003-04 CAO Proposed Budget, and we are unable to amendment a budget not yet adopted, we plan to adjust the Fiscal Year 2003-04 budget as part of the CAO's Proposed Supplemental Budget Resolution in September 2003.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

Beginning in the early 1990s, Prop 99 funding, initially intended to support trauma systems statewide, adequately funded the trauma system, but has steadily decreased over the last decade. Beginning with the last contract in FY 2000-01, other sources of funding, i.e., SB 612/EMS Maddy Funds, Tobacco Settlement Designation Funding and State Trauma Care Funds, have been used to augment the Prop 99 funding in an ongoing effort to fund the trauma system. The State Trauma Fund was developed out of a statewide effort (*Save California Trauma Centers Coalition*) to develop a permanent funding source for trauma centers throughout the State. The total of $25 million allocated statewide for FY 2001-02 was reduced to $20 million in FY 2002-03 and current allocation is pending State legislative appropriation at an even further reduced amount. Additional provisions and funding will serve to ensure continued access to emergency care for Medi-Cal beneficiaries.

The current agreement encompasses multiple components of a comprehensive trauma system including the trauma services, pediatric trauma specialization and base hospital requirements. Similar to the trauma system, the base hospital system has experienced a significant reduction in the number of designated base hospitals. In an effort to stabilize this component of the Advanced Life Support System, trauma centers, except Childrens Hospital Los Angeles, will now be required to perform these services as described in the base hospital contract.

Effective April 1, 2002, six (6) hospitals were designated as Pediatric Trauma Centers, based upon requirements in the revised trauma regulations. Under this agreement and specific regulatory requirements, comprehensive trauma care will be provided to pediatric patients which make up about 10% of the trauma patients.

Three County-operated trauma centers will sign Memorandum of Understandings similar to Exhibit I which is a large part of maintaining the Los Angeles County Trauma Center System.

Three County-operated trauma centers will sign Memorandum of Understandings similar to Exhibit I which is a large part of maintaining the Los Angeles County Trauma Center System.

The provisions of the agreement are provided in Exhibit I, and attached Exhibits A through F.

Attachments A and B provide additional information.

The agreement (Exhibit I), including Exhibits A through F, have been approved as to form by County Counsel.

CONTRACTING PROCESS:

Non-County hospitals executing trauma center service agreements are current participants in the County's trauma system and satisfy the State and County criteria and conditions for such participation.

It is not appropriate to advertise these agreements on the Office of Small Business' Countywide Web Site.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

Approval of these agreements and budget adjustment will maintain the current level of trauma services until June 30, 2005.

When approved, this Department requires three signed copies of the Board's action.

Respectfully submitted,

Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

TLG:pm

Attachments (2)

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Auditor-Controller
Chair, Emergency Medical Services Commission
Health Care Association of Southern California
Chief, County Health Services Branch
State Department of Health Services

BLETCD2913.CBA
cba:06/06/03

ATTACHMENT A

SUMMARY OF AGREEMENTS

1. TYPE OF SERVICE:

   Trauma Services at ten non-County operated hospitals and three County-operated hospitals.

2. LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY:

   Department of Health Services
   Emergency Medical Services Agency
   5555 Ferguson Drive, Suite #220
   Commerce, California 90022
   Attention: Carol S. Gunter, Acting Director
   Telephone: (323) 890-7545

3. HOSPITALS:

   See Attachment B.

4. TERM OF AGREEMENTS:

   The ten non-County agreements and the three County Memorandum of Understanding Agreements will become effective on July 1, 2003 through June 30, 2005.

5. FINANCIAL INFORMATION:

   For Fiscal Years 2003-04 and 2004-05, the total monetary commitment to private trauma centers is $23.89 million annually.

   Financing is offset in part by funding available under State law through the Proposition 99/California Health Care for Indigents Program (CHIP) and the Maddy Emergency Medical Services Fund (SB612) of approximately $5.3 million annually. The remaining financing in the approximate annual amount of $18.59 million will be funded by an allocation of revenue generated by the special tax under Measure B, Preservation of Trauma Centers and Emergency Medical Services; Bioterrorism Response. However, separate Federal matching funds, if approved will reduce this funding from Measure B by approximately $1.13 million. Funding is for the period beginning July 1, 2003, through June 30, 2005.

6. GEOGRAPHIC AREA SERVED:

   Countywide.

7. ACCOUNTABLE FOR PROGRAM MONITORING:

   Local EMS Agency.

8. APPROVALS:

Local EMS Agency:	Carol S. Gunter, Acting Director
Contracts and Grants Division:	Riley J. Austin, Acting Chief
County Counsel (approval as to use):	Edward A. Morrissey, Deputy County Counsel

ATTACHMENT B

DESIGNATED TRAUMA CENTERS

NON-COUNTY TRAUMA CENTERS	LEVEL	PEDIATRIC TRAUMA CENTER	BASE HOSPITAL
Cedars-Sinai Medical Center	I	X	X
Childrens Hospital Los Angeles		X	
Henry Mayo Newhall Memorial Hospital	II		X
Huntington Memorial Hospital	II		X
Long Beach Memorial Medical Center	II	X	(Pending)
Northridge Hospital Medical Center	II		X
Providence Holy Cross Medical Center	II		X
St., Francis Medical Center	II		X
St., Mary Medical Center	II		X
UCLA Medical Center	I	X	X
COUNTY OPERATED TRAUMA CENTERS			
Harbor-UCLA Medical Center	I	X	X
LAC+USC Medical Center	I	X	X
Martin L. King Jr.,/Drew Medical Center	I		X

COUNTY OF LOS ANGELES

TRAUMA CONTRACT FISCAL YEARS 2003 - 2005

Los Angeles County Department of Health Services
Emergency Medical Services Agency
5555 Ferguson Drive, Suite 220
Commerce, California 90022

TRAUMA CENTER
SERVICE AGREEMENT
TABLE OF CONTENTS

TRAUMA CENTER
SERVICE AGREEMENT
TABLE OF CONTENTS

EXHIBIT 1 / Contract # _____

TRAUMA CENTER
SERVICE AGREEMENT

THIS AGREEMENT is made and entered into this_____ day of _____, 2003,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and _____ (hereafter "Contractor").

WHEREAS , various general acute care hospitals located within Los Angeles County have been identified by County as hospitals which are uniquely staffed and equipped to provide appropriate care to emergency patients who suffer major trauma; and

WHEREAS , Contractor is willing to accept and care for trauma patients at hospital under County's advanced trauma system and in accordance with the terms and conditions which follow herein; and

WHEREAS , Contractor, by virtue of the parties' execution of this Agreement, is a County designated Trauma Center; and

WHEREAS , this Agreement establishes funding available to Contractor for certain services performed during the term of this Agreement for services to be performed by Contractor described herein in accordance with the terms and conditions under this

Agreement; and

WHEREAS , Contractor has agreed to use its best efforts to maintain continuous participation as a County-designated Trauma Center and Paramedic Base Hospital during the term of this Agreement; and

WHEREAS , the Agreement is authorized by Health and Safety Code sections 1797.204, 1797.252, and 1798.170, Government Code section 26227, as well as by provisions of WIC Section 16946.

NOW , THEREFORE , the parties agree as follows:

1. TERM:

   A. This Agreement shall commence effective July 1, 2003, and it shall remain in full force and effect until June 30, 2005, without further action of the parties. In any event, County may terminate this Agreement in accordance with the TERMINATION Paragraphs of the ADDITIONAL PROVISIONS hereunder.

   B. Notwithstanding any other provision of this Agreement, Director of County's Department of Health Services or his duly authorized designee (jointly hereafter referred to as "Director") may immediately suspend this Agreement at any time if Contractor's license to operate basic or comprehensive emergency services is revoked or suspended. If such licensure, suspension,

or revocation remains in effect for a period of at least sixty (60) days, Director may terminate this Agreement upon giving at least thirty (30) days prior written notice to Contractor.

C. Notwithstanding any other provision hereof, Director may suspend this Agreement immediately upon giving written notice to Contractor, if Contractor, its agents, subcontractors, or employees at Contractor may be engaging in a continuing course of conduct which poses an imminent danger to the life or health of patients receiving or requesting medical care and services at Contractor. Any such action by Director shall be subject to the "due process" procedures established in Paragraph 16 hereinbelow.

D. Notwithstanding any other provision of this Agreement, either party may terminate this Agreement with or without cause by giving the other party at least sixty (60) days prior written notice thereof. This provision shall not affect County's right to terminate this Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

E. If the State EMS Authority and the State EMS Commission disapprove for any reason the County's trauma system

plan, County may terminate this Agreement by providing written notice to Contractor of the State's action, and by setting forth in the notice an effective date of termination which is no less than thirty (30) days from the date of the County's receipt of notification of the State's action, but which is no more than sixty (60) days from said date.

F. In accordance with this Agreement, Contractor may, during the term of this Agreement, submit claims for services provided to eligible indigent patients. In consideration for services to be performed by Contractor under this Agreement, these claims will be reimbursed at the all-inclusive rates set forth in Exhibit B.

2. ADDITIONAL PROVISIONS: Attached hereto and incorporated herein by reference, is a document labeled "ADDITIONAL PROVISIONS". The terms and conditions therein contained are part of this Agreement.

3. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY):

A. The Department of Health Services ("Department") shall develop and monitor compliance with triage protocols

and procedures for County's trauma system.

B. The Department shall be responsible for the development and ongoing evaluation and Performance Improvement of the trauma system.

C. The Department shall be responsible for periodic performance evaluations of the trauma system, which shall be conducted at least every two (2) years. The evaluation shall be based, in part, on requirements described in Exhibit "A.I", Level I Trauma Center Requirements, Exhibit "A.II", Level II Trauma Center Requirements, Exhibit "A.III", Level I Pediatric Trauma Center Requirements, and Exhibit "A.IV", Level II Pediatric Trauma Center Requirements, attached hereto and incorporated herein by reference. Results of the trauma evaluation shall be made available to individual participants.

D. The Department shall implement policies and procedures for quality improvement in order to monitor the appropriateness and quality of care rendered to trauma patients in Los Angeles County as described under Paragraph 15 hereinbelow.

E. The Department shall be responsible for maintaining a source of reimbursement for eligible indigent patients

described in Exhibit "B", Provisions For Reimbursement of Eligible Indigent Patients, attached hereto and incorporated herein by reference.

F. One or more individuals within the Department shall be designated by Director to liaise with all Los Angeles County designated Trauma Centers with respect to matters affecting County's advanced trauma system.

G. The Department shall be responsible for ensuring that Trauma Centers and other hospitals that treat trauma patients participate in the data and quality improvement process.

H. The Departments shall be responsible for ensuring that patient inclusion in the data collection system is based on Exhibit "C", Patient Inclusion in the Trauma Center Data System, attached hereto and incorporated herein by reference.

I. The Trauma Center data collection system requirements are described and set forth in Exhibit "D", Trauma Center Data Collection System, attached hereto and incorporated herein by reference. The Department shall comply with all Department responsibilities for the Trauma Center data collection system in Exhibit "D".

J. The Department, after consultation with and advice from

the Emergency Medical Services Commission ("EMSC"), EMS Data Advisory Committee shall maintain a comprehensive Trauma Center data collection system. The composition of the EMS Data Advisory Committee, is described in Exhibit "E", Data Advisory Committee Membership, attached hereto and incorporated herein by reference.

K. The Department shall monitor the trauma patient catchment area defined for Contractor to ensure that trauma patients are triaged appropriately to Contractor. Contractor acknowledges receipt of a map defining its catchment area as of the date of execution of this Agreement.

L. The Department may modify trauma patient catchment areas from time to time to meet the needs of the advanced trauma system. In the event that a catchment area is to be changed, then sixty (60) days prior to the effective date of the change, the Department shall give written notice to all designated Trauma Centers. All impacted Trauma Centers which are not County operated, including Contractor, shall be afforded the opportunity to provide written statements regarding the proposed change. If Contractor is adversely affected by the change of the catchment areas, Contractor shall

be provided with "due process" as specified in Paragraph 16 hereinbelow prior to the change in the catchment areas.

M. In the event that an existing Trauma Center ceases to participate in the advanced trauma system, the Department shall first attempt to reconfigure the trauma patient catchment areas so as to provide coverage for the area no longer served by such hospital by utilizing existing Trauma Centers. If coverage cannot be provided by the use of existing Trauma Centers, the Director shall give written notice to Contractor and to all concerned designated Trauma Centers of any Department intention to seek a new hospital to provide the coverage. Contractor and all other concerned designated Trauma Centers shall have the opportunity to provide written statements to Director within ten (10) days of receipt of such notification regarding the proposed change. If Contractor believes it would be adversely affected by the addition of a new Trauma Center in such circumstances, Contractor may present its complaint in accordance with the "due process" provisions specified in Paragraph 16 hereinbelow prior to County designation

of the new Trauma Center.

N. Interim System Re-Configuration. The Department may, on an interim basis, restructure the trauma system as it deems necessary, in those instances when a Contractor gives notice that it is withdrawing from the system or when a Contractor is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, any affected Contractor shall be given the opportunity to provide written and oral statements regarding the restructuring to the local EMS agency. The affected existing Contractors shall be provided with the "due process" procedures as specified in Paragraph 16 hereinbelow.

O. The Department shall follow the trauma system policy which addresses the coordination with all health care organizations within the trauma system to facilitate the transfer of an organization member in accordance with the criteria set forth in Paragraph 11 hereinbelow.

4. SPECIFIC RESPONSIBILITIES OF CONTRACTOR:

A. Contractor shall furnish Trauma Center services to patients in need thereof who are delivered, or present themselves, to Contractor. In the provision of such

services, Contractor shall comply at all times during the term of this Agreement with the staffing criteria and other requirements of applicable Exhibits "A.I" - "A.IV".

B. The Contractor shall comply with the reimbursement process for eligible indigent patients described in Exhibit "B", attached hereto and incorporated herein by reference

C. The Contractor shall include only those patients that meet inclusion in the data collection system based on Exhibit "C", attached hereto and incorporated herein by reference.

D. The Contractor shall comply with all Contractor responsibilities for the Trauma Center data collection system in Exhibit "D", attached hereto and incorporated herein by reference.

E. It is understood and agreed that medical care furnished to patients pursuant to this Agreement shall be provided by physicians duly licensed to practice medicine in the State of California, and the agreement by Contractor to arrange for the furnishing of such treatment at hospital is not to be construed as Contractor entering into the practice of medicine.

This provision shall not limit the right of practitioners or nursing personnel affiliated with or employed by Contractor at hospital to render any and all services within the scope of their professional licensure or certification, as permitted by Contractor's rules, regulations, and policies with respect thereto.

F. Contractor shall maintain designation as a base hospital, furnish base hospital services, and meet all requirements set forth in Exhibit "F", Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference. The foregoing base hospital requirement shall not apply to Childrens Hospital Los Angeles.

5. INDEMNIFICATION: Contractor shall indemnify, defend, and hold harmless County, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with Contractor's acts and/or omissions arising from and/or relating to this Agreement.

County shall indemnify, defend, and hold harmless

Contractor and its officers, employees and agents, from and against any and all liability including but not limited to demands, claims, actions, fees, costs and expenses (including attorney and expert witness fees), arising from or connected with County's acts and/or omissions arising from and/or relating to this Agreement.

6. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County, and during the term of this Agreement, Contractor shall provide and maintain, and shall require all of its subcontractors to maintain, the following programs of insurance specified in this Agreement. Such insurance shall be primary to and not contributing with any other insurance of self-insurance programs maintained by County, and such coverage shall be provided and maintained at Contractor's own expense.

   A. Evidence of Insurance: Certificate(s) or other evidence of coverage satisfactory to County shall be delivered to County's Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor-East, Los Angeles, California 90012, prior to commencing services under this Agreement. Such certificates or other evidence shall:

      (1) Specifically identify this Agreement.

(2) Clearly evidence all coverages required in this Agreement.

(3) Contain the express condition that Contractor will use best efforts to give County written notice by mail at least thirty (30) calendar days in advance of cancellation for all policies evidenced on the certificate of insurance. Should Contractor receive notice from insurer of a cancellation to take effect earlier than thirty (30) calendar days from such notice, Contractor shall use best efforts to notify County in writing of such cancellation on the next business day.

(4) Include copies of the additional insured endorsement to the commercial general liability policy, adding County of Los Angeles, its Special Districts, its officials, officers, and employees as insurers for all activities arising from this Agreement.

(5) Identify any deductibles or self-insured retentions for County's approval. Contractor shall be responsible for all deductibles as they apply to any insurance coverage with respect to this agreement.

B. Insurer Financial Ratings: Insurance is to be provided by an insurance company acceptable to County with an A.M. Best rating of not less than A:VII, unless otherwise approved by County.

C. Failure to Maintain Coverage: Failure by Contractor to maintain the required insurance, or to provide evidence of insurance coverage acceptable to County, shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement. County, at its sole option, may obtain damages from Contractor resulting from said breach.

D. Notification of Incidents, Claims, or Suits: Contractor shall report to County:

(1) Any third party claim or lawsuit filed against Contractor arising from or related to services performed by Contractor under this Agreement.

(2) Any loss, disappearance, destruction, misuse, or theft of any kind whatsoever of County property, monies or securities entrusted to Contractor under the terms of this Agreement.

(3) Simultaneously, any injury, death or treatment of a patient provided services covered in this Agreement for which Contractor provides any

report/notice to the Joint Commission on Accreditation of Hospital Organization (JCAHO), or any report/notice as required under Title 22, C.C.R.70737 (e.g., unusual occurrence). Such report to County shall only include the patient name, date, and treatment.

E. Insurance Coverage Requirements for Subcontractors: Except as set forth below, Contractor shall ensure that any and all non-physician subcontractors (e.g. pump technicians) performing medical care and treatment services under this Agreement shall meet the professional liability insurance requirements of this Agreement by either:

(1) Contractor providing evidence of insurance covering the activities of subcontractors, or

(2) Contractor providing evidence submitted by subcontractors evidencing that subcontractors maintain the required insurance coverage. County retains the right to obtain copies of evidence of subcontractor insurance coverage at any time.

The amount of professional liability insurance required in this Agreement for non-physician subcontractors would be an amount equal to that which

the County routinely requires in its agreements with non-physician contractors providing similar medical care and treatment services to the County.

F. Insurance Coverage Requirements for Affiliate Physicians: Contractor shall ensure that any and all physicians, either individually, or by or through a related medical group, physician group, or independent physician association where appropriate, with privileges to perform or otherwise performing any services covered under this Agreement on premises of or used by Contractor maintain professional liability insurance covering liability arising from any error, omission, negligent, or wrongful act of such physician(s) with limits of not less than $1 million per occurrence and $3 million aggregate. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement, only if such coverage is consistent with the industry standard in California.

7. SPECIFIC INSURANCE COVERAGE REQUIREMENTS:

A. General Liability Insurance: (written on ISO policy form CG 00 01 or its equivalent) with limits of not less than the following:

General Aggregate: $2 Million

Personal and Advertising Injury: $1 Million

Each Occurrence: $1 Million

B. Automobile Liability Insurance: (written on ISO policy form CA 00 01 or its equivalent) with a limit of liability of not less than $1 Million for each accident. Such insurance shall include coverage for all "owned", "hired", and "non-owned" vehicles, or coverage for "any auto".

C. Workers Compensation and Employer's Liability: Insurance providing workers compensation benefits, as required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible. If Contractor's employees will be engaged in maritime employment, coverage shall provide workers compensation benefits as required by the U.S. Longshore and Harbor Worker's Compensation Act, Jones Act, or any other Federal law for which Contractor is responsible.

In all cases, the above insurance also shall include Employers' Liability coverage with limits of not less than the following:

Each Accident: $1 Million

Disease - Policy Limit: $1 Million

Disease - Each Employee $1 Million

D. Professional Liability: Insurance maintained by Contractor covering liability arising from any error, omission, negligent or wrongful act of Contractor, its officers, or employees with limits of not less than $3 Million per occurrence. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement.

8. WAIVERS: Director may waive trauma center criteria contained in Exhibits "A.I" - "A.IV", when it is determined that the conditions necessitating the waiver request will be in effect less than seventy-two (72) hours for any one occurrence and that procedures exist to ensure that patient care is not jeopardized. Waivers may, upon discretion of Director, include but not be limited to the following instances:

A. Temporary inability of Contractor to meet staffing requirements with regard to trauma team or any in-house or on-call or second call physicians whose absence, as determined by Director, would not jeopardize the welfare of trauma patients.

B. Temporary loss of function or restricted capacity of

any of the special facilities, resources or capabilities of Contractor, if such loss or restriction would not jeopardize the welfare of trauma patients. County recognizes that routine servicing and subsequent temporary inoperability ("down time") of the Computerized Tomography (CT) scanner does not require invocation of a waiver.

Contractor shall direct its waiver request to Director's office. If a waiver is given, Contractor shall recontact Director as soon as the temporary staffing or the equipment deficiency for which the waiver was given has been resolved. If a deficiency has not been corrected within the time deemed appropriate by Director, Director may temporarily suspend Contractor's designation as a Trauma Center. In this event, Contractor shall notify surrounding base hospitals and Trauma Centers, and paramedic provider agencies serving Contractor's area that it is on temporary bypass status. When the deficiency necessitating bypass status has been corrected, Director may lift the suspension, and Contractor shall immediately notify such surrounding hospitals.

9. STANDARDS OF CARE:

A. Contractor shall provide for supervision and monitoring of care rendered under the terms of this Agreement in accordance with the recognized standards thereof through regular review of patient medical records by Contractor's appropriately designated medical staff committee(s) at hospital. In addition, Contractor shall provide for specific quality improvement activities as described in the QUALITY IMPROVEMENT Paragraph 15, hereinbelow.

B. Contractor shall:

(1) maintain Contractor's accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be in conformance at hospital with the standards of the JCAHO which apply to the provision of emergency medical services.

(2) not subject trauma patients to avoidable delay in receiving necessary medical care at Contractor pending financial arrangements.

10. NUMBER OF PATIENTS TO BE TREATED: While the parties contemplate that persons suffering major trauma at locations near Contractor will normally be delivered to Contractor for care, the parties recognize that County can make no

guarantee in this regard and further that County is unable to assure that any minimum number of trauma patients will be delivered to Contractor during the term of this Agreement.

11. PATIENT TRANSFERS:

A. Patients to whom service is being provided hereunder may be transferred between and from trauma centers to other medical facilities, including County-operated facilities, in compliance with JCAHO standards, Title 22 of the California Administrative Code, Emergency Medical Treatment and Active Labor Act (EMTALA), and other laws and protocols governing such transfers, providing that:

(1) any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and

(2) in accordance with local EMS agency interfacility transfer policies; and

(3) the transfer may not be refused if the receiving facility has the capacity to accept.

B. Contractor agrees to continue to provide services hereunder until a patient is transferred.

C. Contractor shall have written transfer agreements with trauma centers. Contractor shall develop written criteria for consultation and transfer of patients

needing a higher level of care.

D. To the extent that it is not contrary to, or inconsistent with, any Federal of State law, regulation or policy, the County shall take the necessary steps to insure the preference is given to Contractor seeking to effectuate a medically prudent transfer of a patient to a County owned facility.

E. Contractor or other responsible party shall be financially liable for transportation of patients for whom services are rendered hereunder and who are being transferred from Contractor to any other facility. Nothing herein shall prevent Contractor from billing the patient or other financially responsible party for such services.

12. TRAUMA CENTER SIGNS: Contractor may, at its own expense, identify itself as a Trauma Center by placing signs to that effect on Contractor's grounds. Such signs shall exclude any reference to the level of its County designation and shall otherwise conform to local government regulations.

13. TRAUMA TEAM: Contractor agrees to designate trauma teams, whose members must include the general surgeon, and other team members as appropriate to respond to all trauma codes called either from the field or from the hospital. Upon

activation of the trauma code, appropriate team members shall be available as defined in regulations and shall assemble in the trauma resuscitation area.

14. TRAUMA CENTER FEES: By payment as set forth in this paragraph, Contractor agrees to offset a portion of the cost of the data collection effort excluding new hardware, the data management system, and a portion of the County's administrative costs for the trauma system. For the contract period beginning July 1, 2003 and ending June 30, 2005, the annual Trauma Center fee shall be $32,930 for each Contractor and is due on or before August 31 of the fiscal year.

If this Agreement is revoked, cancelled, or otherwise terminated on a date other than June 30, the amount reflected herein above for such term shall be prorated, and a reduced amount, based upon the actual number of days of such term that the Agreement is in effect, shall be due County hereunder. If the greater sum has already been paid by Contractor, County shall refund the difference between that payment and the prorated amount.

If this Agreement is revoked, cancelled, or terminated because of Contractor's failure to maintain the trauma system criteria as described in applicable Exhibits "A.I" -

"A.IV", or failure to maintain an acceptable level of trauma care as determined by community standards, Contractor shall not be eligible for any such refund.

In any event, County shall refund to Contractor its prorated share of remaining funds contributed by designated County Trauma Centers to the data collection system, if the total cost of such programs, as determined by the County's Auditor Controller and Director in accordance with standard auditing and accounting practices, is found to be less than the total amount contributed by designated Trauma Centers.

15. QUALITY IMPROVEMENT:

A. Specific rights of the Department:

(1) Director may from time to time review Contractor's policies and procedures regarding quality improvement as they pertain to care rendered under this Agreement.

(2) Director may request Contractor to verify that internal follow up is occurring by Contractor on a particular case under review by the Department. Contractor shall respond in writing within fifteen (15) days of Director's written request.

B. Specific responsibilities of Contractor:

(1) Contractor shall conduct a detailed audit of:

(a) all trauma related deaths;

(b) all trauma patient transfers;

(c) all major complications.

(2) Contractor shall abide by the following requirements concerning case audit:

(a) Audit attendances must be documented by signature and rosters retained by Contractor;

(b) Audit minutes must be recorded and retained by Contractor.

(3) All such records shall be available to designees duly authorized by Director during the term of this Agreement and for a period of seven (7) years thereafter upon request of Director.

(4) Contractor shall further advise Director, upon request, what corrective action was taken on specific cases.

16. DUE PROCESS:

A. Notice of Proposed Adverse Action: In all cases in which the Director has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as hereafter set forth in Subparagraph 16.B., Contractor shall promptly be given written notice of the specific charges and

factual basis upon which the Director's action is based. With the exception of summary suspensions or summary suspension with intent to terminate, Contractor shall be afforded a right to request a hearing before implementation of any of the actions which constitute grounds for a hearing. Contractor shall have thirty (30) days following the receipt of such notice within which to file with Director a request for hearing before the EMSC.

B. Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing: summary suspension of Contractor as a Trauma Center; summary suspension with intent to terminate Agreement; Trauma Center operational and programmatic changes wherein Contractor has been given specific rights herein to request a hearing; modifications to Contractor's trauma patient catchment area; and the proposed addition of a new hospital as a Trauma Center when Contractor believes it would be adversely affected by such addition. Nothing in this paragraph 16 shall affect County's right to terminate Agreement under subparagraph 1.D.

C. Summary Suspension or Summary Suspension with Intent To

Terminate: In the case of summary suspensions or summary suspension with intent to terminate this Agreement, Contractor, at its election, shall have the right to request in writing that Director reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) days after the receipt of the reconsideration request. Contractor representatives shall be given an opportunity to meet with Director to discuss the alleged basis for the summary action.

Within ten (10) days following the meeting with Director, or within ten (10) days following the summary suspension action, Director shall issue a written decision to Contractor regarding the summary suspension. This decision may be that the suspension be continued for a particular time or upon particular condition, that the summary suspension be terminated, that Agreement be terminated, that other conditions be imposed on Contractor, or such other action as may seem warranted. If Director takes any action other than full and immediate termination of the summary suspension, Contractor may request a hearing on the summary suspension before the EMSC, as provided in this

Paragraph. Such request shall be in writing and addressed to Director. Such request shall be delivered to Director within five (5) days of Director's delivery to Contractor of his/her written decision.

D. Time and Place of Hearing: Director shall, within fifteen (15) days of receipt of a request for hearing, file a request for the hearing with the EMSC. The EMSC shall give notice to Contractor of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the filing of the request for a hearing, subject to the convenience and approval of the EMSC; however, if the request is received from Contractor when Contractor is under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible.

E. Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Contractor is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who

will appear on behalf of the other, then each party, within ten (10) days of such request, shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

F. Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.

G. Memorandum of Points and Authorities: Subject to the rules of the EMSC, each party shall have the right to submit a memorandum of points and authorities to the EMSC.

H. Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:

(1) oral testimony of the parties' representatives;

(2) documentary evidence introduced at the hearing;

(3) briefs or memorandum of points and authorities presented in connection with the hearing;

(4) policies and procedures of the Department;

(5) all officially noticed matters.

I. Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, a tape or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Contractor or by Director, the cost of same shall be borne by such party.

J. Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070B.

17. RESPONSIBILITY FOR INDIGENT PATIENTS: Nothing contained in this Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

18. STATUS OF CONTRACTOR: The parties hereto agree that Contractor, its officers, agents, and employees, including its professional and nonprofessional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefits of

County employees. Except as may otherwise expressly be provided hereunder, Contractor shall furnish all personnel, supplies, equipment, space, furniture, insurance, utilities, and telephone necessary for performance of Contractor's responsibilities set forth in this Agreement. This Paragraph shall not preclude or limit Contractor from seeking reimbursement, contributions, tuition, or other payments from the public or from non-County provider agencies for services provided by Contractor hereunder where entitlement thereto is permitted by law or by separate contract.

19. INTERPRETERS: If Contractor is located in an area where communication problems may exist because of a high concentration of non-English-speaking residents, Contractor shall provide interpreters in accordance with the requirements for such services established under Section 70721, Title 22 of the California Administrative Code.

20. CONSUMER COMPLAINTS:

A. Contractor agrees to comply with all responsibilities and related requirements applicable under Section 70707, Title 22 of the California Administrative Code, to ensure that each patient receiving services hereunder at Contractor is made aware of the following

information prior to discharge: the name, location, and telephone number of Contractor's representative responsible for handling patient complaints; means, including forms, for submitting complaints in writing to that representative; a "Bill of Rights" defining patient prerogatives relative to matters on care, services, communication, and registry of complaints.

B. Contractor shall, on request, furnish to Director, copies of all trauma patient complaints, and the results of Contractor's investigation and action taken. All of Contractor's administrative files maintained on such complaints shall be open to inspection by Director. Such inspection rights shall not extend to reports of medical staff committees, nor to incident reports or other attorney-client communication or materials qualifying for the attorney-client privilege.

21. NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by United States mail, certified or registered postage prepaid return receipt requested, to the parties at the following addresses and to the attention of the persons named. County's Director shall have the

authority to issue all notices which are required or permitted by County hereunder. Addresses and persons to be notified may be changed by a party by giving at least ten (10) calendar days prior written notice thereof to the other.

A. Notices to County shall be addressed as follows:

(1) Department of Health Services
Emergency Medical Systems Division
5555 Ferguson Drive, Suite 220
Commerce, California 90022
Attention: Director

(2) Department of Health Services
Contracts and Grants Division
313 North Figueroa Street
Sixth Floor - East
Los Angeles, California 90012
Attention: Division Chief

B. Notice to Contractor shall be addressed as follows:

_____
_____
_____
_____
Attention: Chief Executive Officer

EXHIBIT 1

IN WITNESS WHEREOF , the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

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Director of Health Services and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

_____
Contractor

By _____
Signature

_____
Printed Name

_____
Title

_____
Date

(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
Lloyd W. Pellman
County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Health Services

By _____
Chief, Contracts and Grants
Division

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

1. ADMINISTRATION AND MONITORING:

A. Director or his authorized designee shall have the authority to administer this Agreement on behalf of County.

B. Contractor extends to Director the right to review and monitor Contractor's trauma program policies and procedures pertinent to this Agreement and to inspect Contractor's facility and records for contractual compliance with State and local EMS Agency policies and regulations.

Inspection by County staff shall be conducted during County's normal business hours and only after giving Contractors at least three (3) working days prior written notice thereof. In computing the three working days, a Saturday, Sunday, or legal holiday shall not be included. Said notice need not be given in cases where Director determines that the health and welfare of trauma system patients would be jeopardized by waiting three (3) days. Nothing herein shall preclude County staff authorized by Director from making unannounced visits to determine compliance with

criteria contained in Exhibits "A.I"-"A.IV", attached hereto and incorporated herein by reference.

2. CONTRACT COMPLIANCE: Should Contractor, as initially determined by Director, fail to comply with any provision set forth hereunder as a Contractor responsibility or obligation, Director may do any or all of the following in addition to other rights which Director of County may have hereunder or at law:

   A. Send Contractor a written warning itemizing the area(s) of concern and requesting or specifying a plan for remedial action.

   B. Send Contractor a written itemized listing of the area(s) of concern and permit Contractor to voluntarily request temporary suspension of Contractor for a period of thirty (30) days or less to allow for remedial action to be taken.

   C. Send Contractor a written itemized listing of the area(s) of concern and summarily suspend, or summarily suspend with intent to terminate, Contractor. Any such action by County shall be subject to the "due process" procedures established in Paragraph 16 of the body of the Agreement.

3. LICENSES: Contractor shall obtain and maintain, during the

term of this Agreement, all appropriate licenses required by law for operation at its facility and for the provision of services hereunder. Contractor, in its operation, shall also comply with all applicable local, state, and Federal statutes, ordinances, and regulations.

4. CONFIDENTIALITY: Contractor agrees to maintain the confidentiality of its records, including billings, in accordance with all applicable State, Federal, and local laws, ordinances, rules, regulations, and directives relating to confidentiality. Contractor shall inform all of its officers, employees, and agents, and others providing services hereunder of said confidentiality provisions. County shall maintain the confidentiality of patient medical records made available hereunder in accordance with the customary standards and practices of governmental third party payers.

5. RECORDS AND AUDITS:

   A. Records of Services Rendered: Contractor shall maintain books and records of services rendered to all patients provided trauma service at Contractor hereunder, including discharge dispositions, in accordance with Contractor's customary record-keeping requirements. All patient records must comply with

general acute care hospital licensure requirements and JCAHO standards applicable to books and records of services rendered. Such books and records shall be retained by Contractor for a minimum period of seven (7) years following the discharge of a patient. Patient records for minors shall be retained either for seven (7) years following the discharge of the patient or until the minor's 19th birthday, whichever is later. During such seven (7) year period, all such records, as well as other records and reports maintained by Contractor pertaining to this Agreement, shall be retained by Contractor at a location in Los Angeles County, and shall be available during Contractor's normal business hours to duly authorized representatives of Director upon request for review and copying.

In the event County staff desire to conduct any review of Contractor's records authorized under this Paragraph, Contractor shall be given written notice at least ten (10) days in advance of any such review. Said notice need not be given in cases where Director determines that the health and welfare of trauma system patients would be jeopardized by waiting ten (10) days.

Contractor's Director of Utilization Review and its Director of Medical Records shall be permitted to participate in the review and Contractor shall fully cooperate with County's representatives. Contractor shall allow County's representatives access to all medical records and reports, and other records pertaining to this Agreement, and shall allow photocopies to be made of these documents utilizing Contractor's photocopier, for which County shall reimburse Contractors at County's customary rate for record copying services. Such inspection rights shall not extend to the proceedings or records of Contractor's organized committees or its medical staff, having as their responsibility the evaluation and improvement of the quality of care rendered in the hospital, which are protected by Evidence Code, Section 1157. An exit conference shall be held following the performance of such review activities at which time the results of the review shall be discussed with Contractor representatives prior to the generation of any final written report or action by Director based on such audit or review. The exit conference shall be held on site prior to the departure of the reviewers

and Contractor representatives shall be provided with an oral or written list of preliminary findings at the exit conference.

B. Federal Access to Records: If, and to the extent that, Section 1861 (v) (1) (I) of the Social Security Act [42 U.S.C. Section 1395x (v) (1) (I)] is applicable, Contractor agrees that for a period of four years following the furnishing of trauma services to a patient by Contractor, Contractor shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human Services or to the Comptroller General of the United States, or to any of their duly authorized representatives, the contract, books, documents, and records of Contractors which are necessary to verify the nature and extent of the cost of such services. Furthermore, if Contractor carries out any of the services provided hereunder through a subcontract with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve-month period with a related organization (as that term is defined under Federal law), Contractor agrees that each such subcontract shall provide for such access to the subcontract,

books, documents, and records of the subcontractor.

6. COUNTY'S QUALITY ASSURANCE PLAN: County or its Agents will evaluate Contractor's performance under this Agreement at least every two (2) years. Such evaluation will include assessing Contractor's compliance with all contract terms and performance standards. Contractor deficiencies which County determines are severe or continuing and that may place performance of this Agreement in jeopardy if not corrected will be reported to the Board of Supervisors. The report will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective action measures, County may terminate this Agreement or impose other penalties as specified in this Agreement.

7. CONTRACTOR'S PERFORMANCE DURING CIVIL UNREST OR DISASTER: Contractor recognizes that health care facilities maintained by County provide care essential to the residents of the communities they serve, and that these services are of particular importance at the time of riot, insurrection, civil unrest, natural disaster, or similar event. Notwithstanding any other provision of this Agreement, full performance by Contractor during any riot, insurrection, civil unrest, natural disaster, or similar event is not

excused if such performance remains physically possible. Failure to comply with this requirement shall be considered a material breach by Contractor for which Director may suspend or County may immediately terminate this Agreement.

8. INDEPENDENT CONTRACTOR STATUS: This Agreement is by and between the County of Los Angeles and Contractor and it is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between County and Contractor.

Contractor understands and agrees that all Contractor employees furnishing services pursuant to this Agreement are, for purposes of Workers' Compensation liability, employees solely of Contractor and not of County.

Contractor shall bear the sole responsibility and liability for furnishing workers' compensation benefits, if applicable, to any person for injuries arising from, or connected with, services performed on behalf of Contractor pursuant to this Agreement.

9. NONDISCRIMINATION IN SERVICES: Contractor shall not discriminate in the provision of services hereunder because of race, color, religion, national origin, ancestry, sex, age, or physical or mental disability, or medical condition, in accordance with applicable requirements of State and

Federal law.

10. NONDISCRIMINATION IN EMPLOYMENT: Contractor's employment practices and policies shall also meet all applicable State and Federal nondiscrimination requirements.

11. FAIR LABOR STANDARDS ACT: Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its agents, officers, and employees from and against any and all liability including, but not limited to wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law including, but not limited to, the Federal Fair Labor Standards Act for services performed by Contractor's employees for which County may be found jointly or solely liable.

12. EMPLOYMENT ELIGIBILITY VERIFICATION: Contractor warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others, and that all its employees performing services hereunder meet the citizenship or alien status requirements contained in Federal statutes and regulations. Contractor shall retain such documentation for all covered employees for the period prescribed by law. Contractor shall indemnify, defend, and

hold harmless, the County, its officers, and employees from employer sanctions and any other liability which may be assessed against Contractor or County in connection with any alleged violation of Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.

13. STAFF PERFORMANCE WHILE UNDER THE INFLUENCE: Contractor shall use reasonable efforts to ensure that no employee or physician will perform services hereunder while under the influence of any alcoholic beverage, medication, narcotic, or other substance that might impair his/her physical or mental performance.

14. CONSIDERATION OF GAIN PROGRAM PARTICIPANTS FOR EMPLOYMENT: Should Contractor require additional or replacement personnel after the effective date of this Agreement, Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services' Greater Avenues for Independence ("GAIN") Program who meet Contractor's minimum qualification for the open position. The County will refer GAIN participants by job category to the Contractor.

15. CONTRACTOR'S WILLINGNESS TO CONSIDER COUNTY'S EMPLOYEES FOR EMPLOYMENT: Contractor agrees to receive referrals from

County's Department of Human Resources of qualified permanent employees who are targeted for layoff or qualified former employees who have been laid off and are on a re-employment list during the life of this Agreement. Such referred permanent or former County employees shall be given first consideration of employment as Contractor vacancies occur after the implementation and throughout the term of this Agreement.

Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person shall acquire any rights as a third party beneficiary of this Agreement.

16. TERMINATION FOR IMPROPER CONSIDERATION: County may, by written notice to Contractor, immediately terminate the right of Contractor to proceed under this Agreement if it is found that consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment, or extension of the Agreement or the making of any determination with respect to the Contractor's performance pursuant to the Agreement. In the event of such termination, County shall be entitled to

pursue the same remedies against Contractor as it could pursue in the event of default by the Contractor.

Contractor shall immediately report any attempt by a County officer, or employee, or agent to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (213) 974-0914 or (800) 544-6861.

Among other items, such improper consideration may take the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

17. RESTRICTIONS ON LOBBYING: If any Federal monies are to be used to pay for Contractor's services under this Agreement, Contractor shall comply with all certification and disclosure requirements prescribed by Section 319, Public Law 101-121 (Title 31, United States Code, Section 1352) and any implementing regulations, and shall ensure that each of its subcontractors receiving funds provided under this Agreement also fully comply with all such certification and disclosure requirements.

18. COUNTY LOBBYISTS: Contractor and each County lobbyist or County lobbying firm as defined in Los Angeles County Code Section 2.160.010, retained by Contractor, shall fully

comply with the County Lobbyist Ordinance, Los Angeles County Code Chapter 2.160. Failure on the part of Contractor or any County lobbyist or County lobbying firm retained by Contractor to fully comply with the County Lobbyist Ordinance shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement.

19. UNLAWFUL SOLICITATION: Contractor shall inform all of its employees of the provision of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of the Business and Professions Code of the State of California (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of said provision by its employees. Contractor agrees that if a patient requests assistance in obtaining the services of any attorney, it will refer the patient to the attorney referral service of those bar associations within Los Angeles County that have such a service.

20. CONFLICT OF INTEREST: No County officer or employee whose position in County enables him or her to influence the award or County administration of this Agreement or any competing

agreement shall participate in the negotiation of this Agreement. No County employee with a spouse or economic dependent employed in any capacity by Contractor herein, shall participate in the negotiation of this Agreement, or have a direct or indirect financial interest in this Agreement.

No officer, subcontractor, agent, or employee of Contractor who may financially benefit from the provision of services hereunder shall in any way participate in County's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such services.

21. PROHIBITION AGAINST ASSIGNMENT AND DELEGATION:

A. Assignment of Delegation to Subcontractor: Contractor shall not assign its rights or delegate its duties under this Agreement by subcontract, or both, whether in whole or in part, without the prior written consent of County where such assignment or delegation materially changes the operation of the trauma center in performing services under this Agreement. Any assignment or delegation which does not have such prior County consent shall be null and void. For purposes of this Paragraph, such County consent shall require a

written amendment to this Agreement which is formally approved and executed by the parties. Any billings to County by any delegatee or assignee on any claim under this Agreement, absent such County consent, shall not be paid by County. Any payments by County to any delegatee or assignee on any claim under this Agreement, in consequences of any such County consent, shall reduce dollar for dollar any claims which Contractor may have against County and shall be subject to set-off, recoupment, or other reduction for any claims which County may have against Contractor, whether under this Agreement or otherwise.

B. Shareholders or partners, or both, of Contractor may sell, exchange, assign, divest, or otherwise transfer any interest they may have therein. However, in the event any such sale, exchange, assignment, divestment, or other transfer is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of this Agreement, then prior written notice thereof by County's Board of Supervisors shall be required. Any payments by County to Contractor on

any claim under this Agreement shall not waive or constitute such County consent. Consent to any such sale, exchange, assignment, divestment, or other transfer shall be refused only if County, in its sole judgement, determines that the transferee(s) is (are) lacking in experience, capability, or financial ability to perform all Agreement services and other work. This in no way limits any County right found elsewhere in this Agreement, including, but not limited to, any right to terminate this Agreement.

22. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: Contractor shall assure that the locations where services are provided under provisions of this Agreement are operated at all times in accordance with County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances, and regulation relating to the property. County's periodic monitoring visits to Contractor's facilities shall include a review of compliance with the provisions of this Paragraph.

23. CONFLICT OF TERMS: To the extent that any conflict exists between the language of the body of this Agreement and of the language of the exhibits attached hereto, the former

shall govern and prevail.

24. MERGER PROVISION: The body of this Agreement, together with the exhibits attached hereto, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Agreement. No addition to, or alteration of the terms of this Agreement, whether by written or verbal understanding of the parties, their officers, agents, or employees, shall be valid and effective unless made in the form of a written amendment to this Agreement which is formally adopted and executed by the parties in the same manner as this Agreement.

25. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Contractor acknowledges that County has established a goal of ensuring that all individuals who benefit financially from County through County contracts are in compliance with their court ordered child, family, and spousal support obligations in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

As required by County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Agreement to comply with all applicable provisions of law, Contractor warrants that it is

now in compliance and shall during the terms of this Agreement maintain compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 U.S.C. Section 653a) and California Unemployment Insurance Code (Section 1088.55), and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department (CSSD) Notices of Wage and Earnings Assignment for Child or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246 (b).

Within thirty (30) calendar days of the effective date of this Agreement, Contractor shall submit to County's CSSD a completed Principal Owner Information (POI) Form, incorporated herein by reference along with certification in accordance with the provisions of Section 2.200.060 of the County Code, that: (1) the POI Form has been appropriately completed and provided to the CSSD with respect to Contractor's Principal Owners; (2) Contractor has fully complied with all applicable State and Federal reporting requirements relating to employment reporting for its employees; and (3) Contractor has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to maintain

compliance. Such certification shall be submitted on the Child Support Compliance Program (CSCP) Certification, also incorporated herein by reference.

Failure of Contractor to submit the CSCP Certification (which includes certification that the POI Form has been submitted to the CSSD) to County's CSSD shall represent a material breach of contract upon which County may immediately suspend or terminate this Agreement.

26. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in the CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM Paragraph immediately above, shall constitute a default by Contractor under this Agreement. Without limiting the rights and remedies available to County under any other provision of this Agreement, failure to cure such defaults within ninety (90) calendar days of written notice by County's CSSD shall be grounds upon which County's Board of Supervisors may terminate this Agreement pursuant to the Term and Termination Paragraphs of this Agreement.

27. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO CHILD SUPPORT ENFORCEMENT: Contractor acknowledges that County

places a high priority on the enforcement of child support laws and the apprehension of child support evaders. Contractor understands that it is County's policy to encourage all County Contractors to voluntarily post County's "L.A.'s Most Wanted: Delinquent Parents" poster in a prominent position at Contractor's place of business. County's CSSD will supply Contractor with the poster to be used.

28. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: Contractor hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and that Contractor will notify Director within thirty (30) calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Contractor or one or more staff members barring it or the staff members from participation in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Contractor or its staff members from such participation in a Federally funded health care program.

Failure by Contractor to meet the requirements of this Paragraph shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement.

29. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: Contractor shall notify its employees that they may be eligible for the Federal Earned Income Credit under the Federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice 1015.

30. CONTRACTOR RESPONSIBILITY AND DEBARMENT:

A. A responsible contractor is a contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity, and experience to satisfactorily perform the contract. It is County's policy to conduct business only with responsible contractors.

B. Contractor is hereby notified that, in accordance with

Chapter 2.202 of the County Code, if County acquires information concerning the performance of Contractor under this Agreement or other contracts, which indicates that Contractor is not responsible, County may or otherwise in addition to other remedies provided under this Agreement, debar Contractor from bidding on County contacts for a specified period of time not to exceed three (3) years, and terminate this Agreement and any or all existing contracts Contractor may have with County.

C. County may debar Contractor if the Board of Supervisors finds, in its discretion, that Contractor has done any of the following: (1) violated any terms of this Agreement or other contract with County, (2) committed any act or omission which negatively reflects on Contractor's quality, fitness, or capacity to perform a contract with County or any other public entity, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against County or any other public entity.

D. If there is evidence that Contractor may be subject to

debarment, Director will notify Contractor in writing of the evidence which is the basis for the proposed debarment and will advise Contractor of the scheduled date for a debarment hearing before County's Contractor Hearing Board.

E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor or Contractor's representative, or both, shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a proposed decision, which shall contain a recommendation regarding whether Contractor should be debarred, and, if so, the appropriate length of time of the debarment. If Contractor fails to avail itself of the opportunity to submit evidence to the Contractor Hearing Board, Contractor shall be deemed to have waived all rights of appeal.

F. A record of the hearing, the proposed decision, and any other recommendations of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right at its sole discretion to modify, deny, or adopt the proposed

decision and recommendation of the Contractor Hearing Board.

G. These terms shall also apply to any subcontractors of Contractor, vendor, or principal owner of Contractor, as defined in Chapter 2.202 of the County Code.

31. SEVERABILITY: If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

32. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996: The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA). Contractor understands and agrees that, as a provider of medical treatment services, it is a "covered entity" under HIPAA and, as such, has obligations with respect to the confidentiality, privacy and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate

consents and authorizations specified under HIPAA.
The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

33. COMPLIANCE WITH APPLICABLE LAWS: Contractor shall comply with all applicable Federal, State, and local laws, rules, regulations, ordinances, and directives, and all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference.

Contractor shall indemnify and hold harmless the County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, arising from or related to any violation on the part of the Contractor or its employees, agents, or subcontractors of any such laws, rules, regulations, ordinances, or directives.

34. COMPLIANCE WITH CIVIL RIGHTS LAWS: Contractor hereby assures that it will comply with all applicable provisions of the Civil Rights Act of 1964, 42 U.S.C. Sections 2000 (e) (1) through 2000 (e) (17), to the end that no person shall, on the grounds of race, creed, color, sex, religion, ancestry, age, condition of physical handicap, marital status, political affiliation, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.

35. GOVERNING LAW, JURISDICTION, AND VENUE: This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. The Agreement agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

36. SUBCONTRACTING:

A. The overall provisions of trauma services may not be subcontracted by the Contractor without the advance approval of the County. Any attempt by Contractor to subcontract without prior consent of the County may be deemed a material breach of this Agreement.

B. If Contractor desires to subcontract, Contractor shall provide the following information promptly at the County's request:

(1) A description of the work to be performed by the subcontractor.

(2) A draft copy of the proposed subcontract; and

(3) Other pertinent information and/or certifications requested by the County.

C. Contractor shall indemnify and hold the County harmless

with respect to the activities of each and every subcontractor in the same manner and to the same degree as if such subcontractor(s) were Contractor employees.

D. Contractor shall remain fully responsible for all performances required of it under this Agreement, including those that Contractor has determined to subcontract, notwithstanding the County's approval of Contractor's proposed subcontract.

E. The County's consent to subcontract shall not waive the County's right to prior and continuing approval of any and all personnel, including subcontractor employees, providing services under this Agreement. Contractor is responsible to notify its subcontractors of this County right.

F. The County's Project Director is authorized to act for and on behalf of the County with respect to approval of any subcontract and subcontractor employees.

G. Contractor shall be solely liable and responsible for all payments or other compensation to all subcontractors and their officers, employees, agents, and successors in interest arising through services performed hereunder, notwithstanding the County's consent to subcontract.

H. Contractor shall obtain certificates of insurance, which establish that the subcontractor maintains all the programs of insurance required by the County from each approved subcontractor. Contractor shall ensure delivery of all such document to: County of Los Angeles, Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor East, Los Angeles, California 90012, before any subcontractor employee may perform any work hereunder.

37. TERMINATION FOR DEFAULT:

A. The County may, by written notice to Contractor, terminate the whole or any part of this Agreement, if, in the judgment of County's Project Director.

(1) Contractor has materially breached this Agreement;

(2) Contractor fails to timely provide and/or satisfactorily perform any task, deliverable, service, or other work required either under this Agreement; or

(3) Contractor fails to demonstrate a high probability of timely fulfillment of performance requirements under this Agreement, or of any obligations of this Agreement and in either case, fails to demonstrate convincing progress toward a cure

within five (5) working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure.

B. In the event that the County terminates this Agreement in whole or in part as provided in Sub-paragraph 37A above, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. Contractor shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. Contractor shall continue the performance of this Agreement to the extent not terminated under the provisions of this sub-paragraph.

C. Except with respect to defaults of any subcontractor, Contractor shall not be liable for any such excess costs of the type identified in the subparagraph above if its failure to perform this Agreement arises out of causes beyond the control and without the fault or negligence of Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or

contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather, but in every case, the failure to perform must be beyond the control and without the fault or negligence of Contractor. If the failure to perform is caused by the default of a subcontractor, and if such default arises out of causes beyond the control of both Contractor and subcontractor, and without the fault or negligence of either of them, Contractor shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Subparagraph 37C, the terms "subcontractor" and "subcontractors" mean subcontractor(s) at any tier.

D. If, after the County has given notice of termination under the provisions of this Sub-paragraph 37C, it is determined by the County that Contractor was not in default under the provisions of this Sub-paragraph 37C, or that the default was excusable under the provisions

of Sub-paragraph 37B, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to Sub-paragraph 37A.

E. The rights and remedies of the County provided in this Sub-paragraph 37 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

38. NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION/TERMINATION OF AGREEMENT: Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provisions shall survive the expiration or other termination of this Agreement.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.I
LEVEL I TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.I

TRAUMA CENTER REQUIREMENTS

LEVEL I

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

3. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

4. General Surgeon:

"General Surgeon" for the purposes of this trauma system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

5. In-house:

"In-house" means being within the actual confines of the Trauma Center.

6. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

7. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

8. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

9. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the Trauma Center;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the Trauma Center) within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and
c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the Trauma Center the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response

was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

10. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a Trauma Center if:

(1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;

(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

(3) the physician has successfully completed a residency program.

11. Residency Program:

"Residency program" means a residency program of the Trauma Center or a residency program formally affiliated with a Trauma Center where senior residents can participate in educational rotations, which has

been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

12. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

13. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

14. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a Trauma Center where trauma patients are evaluated upon arrival.

15. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a Trauma Center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

16. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to Trauma Center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. GENERAL REQUIREMENTS:

1. A licensed hospital which has been designated as a Level I Trauma Center by the EMS Agency.

2. Appropriate pediatric equipment and supplies and the capability of initial evaluation and treatment of pediatric trauma patients.

3. Establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care when the Trauma Center is without a pediatric intensive care unit.

4. ReddiNet System where geographically available.

5. A trauma program medical director who is a board certified surgeon whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
   a. recommending trauma team physician privileges;
   b. working with nursing and administration to support the needs of trauma patients;
   c. developing trauma treatment protocols;
   d. determining appropriate equipment and supplies for trauma care;
   e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
   f. having authority and accountability for the quality improvement peer review process;
   g. correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
   h. coordinating pediatric trauma care with other hospital and professional services;

i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.

6. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administrative ability, and responsibilities that include but are not limited to:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured patient;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel;
   c. collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

7. A trauma service or multi-disciplinary trauma committee included in their organization which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

8. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.

9. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists:

a. General Surgery
b. Neurologic
c. Obstetric/Gynecologic
d. Ophthalmologic
e. Oral or Maxillofacial or Head/Neck
f. Orthopaedic
g. Plastic
h. Urologic

10. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
    a. Anesthesiology
    b. Emergency Medicine
    c. Internal Medicine
    d. Pathology
    e. Psychiatry
    f. Radiology

11. Commitment by the hospital and its medical staff to treat and care for any patient presenting.

12. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:
    a. Immediately Available:
        (1) General Surgery:
            A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for trauma patients twenty-four (24) hours per day. A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be promptly available for consultation.

            (Requirement may be fulfilled by a supervised senior resident as defined in Section A-12 of

this Exhibit who is capable of assessing emergent situations. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available</u>:

(1) Cardiothoracic
(2) General Surgeon *(Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second general surgeon.)*
(3) Hand
(4) Neurologic (Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)
(5) Obstetric/Gynecologic
(6) Ophthalmic
(7) Oral or Maxillofacial or Head/Neck
(8) Orthopedic
(9) Pediatric
(10) Plastic
(11) Reimplantation/Microsurgery *(This surgical service may be provided through a written*

transfer agreement at Level I and Level II Trauma Centers.)

(12) Urologic

(13) Vascular (Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)

The on-call general surgeon, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for adult and pediatric trauma

patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:
a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, in-house and immediately available at all times.

(This requirement may be fulfilled by supervised senior residents, as defined in Section A-12 of this Exhibit, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)

(2) Anesthesiologist:
Anesthesiology, in-house and immediately available at all times.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of

providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

b. Promptly Available:
(1) Anesthesiologist (Second physician on call.)
(2) Emergency Medicine (Second physician on call.)
(3) Radiologist

The on-call anesthesiologist, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

c. Available for Consultation:
(1) Cardiologist
(2) Gastroenterologist
(3) Hematologist
(4) Infectious Disease Specialist
(5) Internist
(6) Nephrologist
(7) Neurologist
(8) Pathologist
(9) Pediatrician
(10) Pulmonary Disease Specialist

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**
Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
a. designate a Medical Director;
b. maintain an Emergency Medicine Physician in the Emergency Department twenty-four (24) hours per day;
c. designate an emergency physician to be a member of the trauma team;
d. provide emergency medical services to adult and pediatric patients;

e. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
f. designate a trauma resuscitation area of adequate size to accommodate multi-system injured patient and equipment; and
g. comply with current Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available;
b. cardiopulmonary bypass equipment;
c. operating microscope;
d. appropriate surgical equipment and supplies as determined by the trauma program medical director; and
e. Post Anesthetic Recovery Room (PAR) which meets the requirements of California Administrative Code.(A Surgical Intensive Care Unit is acceptable.)

3. **Intensive Care Service:**

In addition to the special permit licensing services, a Trauma Center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, an approved Intensive Care Unit (ICU). The ICU shall:

a. for trauma patients, the ICU's may be separate specialty units;
b. have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
c. have a qualified specialist in house and immediately available to care for the trauma patients in the intensive care unit. (*The qualified specialist may be a resident with two*

(2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making.); and

d. have the qualified specialist in (3) above be a member of the trauma team.

4. **Radiological Service:**

a. The radiological service shall have <u>immediately available</u> a radiological technician capable of performing:
   (1) plain films; and
   (2) computed tomography imaging (CT).

b. A radiological service shall have the following additional services <u>promptly available</u>:
   (1) angiography; and
   (2) ultrasound.

5. **Clinical Laboratory Service:**

A clinical laboratory service shall have:

a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;

b. capability of collecting and storing blood for emergency care; and

c. clinical laboratory services immediately available.

E. <u>SUPPLEMENTAL SERVICES</u>:

1. In addition to the special permit licensing services, a Trauma Center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following <u>approved</u> supplemental services:

a. Burn Center.
   (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if

resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained and equipped for acute care of the critically injured patient:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities (with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours per day)
   (5) Occupational Therapy Service Speech Therapy Service
   (6) Social Service

2. A Trauma Center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
      (1) a pediatric intensive care unit (PICU) approved by the State Department of Health Services' California Children Services (CCS); or pending CCS approval, validation of existing CCS PICU Standards (Attachment A-2) by the County prior to designation as a Pediatric Trauma Center; or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
      (2) a multidisciplinary team to manage child abuse and neglect.
   b. Acute spinal cord injury management capability. *(This service may be provided through a written*

transfer agreement with a Rehabilitation Center.)

c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.

d. An outreach program, to include:
   (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
   (2) trauma prevention for the general public.

e. Written inter-facility transfer agreements with referring and specialty hospitals.

F. QUALITY IMPROVEMENT PROCESS:

Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. VOLUME STANDARDS:

A Level I Trauma Center shall have one of the following patient volumes annually:

1. a minimum of 1200 trauma program center admissions, or

2. a minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is greater than 15, or

3. an average of 35 trauma patients, with an ISS greater than 15, per trauma program surgeon per year.

H. CLINICAL EDUCATION AND RESEARCH:

A Level I Trauma Center shall include the following:

1. Trauma research program with ongoing clinical research in trauma.

2. Accreditation Council on Graduate Medical Education (ACGME) approved surgical, internal medicine and anesthesiology residency programs. A mechanism shall be in place to ensure residents' participation in the acute care of the trauma patient.

3. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

4. Formal continuing education in trauma care. Continuing education in trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.II
LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.II

TRAUMA CENTER REQUIREMENTS

LEVEL II

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

3. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

4. General Surgeon:

"General Surgeon" for the purposes of this trauma system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

5. In-house:

"In-house" means being within the actual confines of the Trauma Center.

6. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

7. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

8. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

9. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and
c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response

was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

10. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

   (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;

   (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

   (3) the physician has successfully completed a residency program.

11. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has

been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

12. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

13. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

14. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

15. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

16. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. GENERAL REQUIREMENTS:

1. A licensed hospital which has been designated as a Level II Trauma Center by the EMS Agency.

2. Appropriate pediatric equipment and supplies and the capability of initial evaluation and treatment of pediatric trauma patients.

3. Establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care when the Trauma Center is without a pediatric intensive care unit.

4. ReddiNet System where geographically available.

5. A trauma program medical director who is a board certified surgeon whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
   a. recommending trauma team physician privileges;
   b. working with nursing and administration to support the needs of trauma patients;
   c. developing trauma treatment protocols;
   d. determining appropriate equipment and supplies for trauma care;
   e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
   f. having authority and accountability for the quality improvement peer review process;
   g. correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
   h. coordinating pediatric trauma care with other hospital and professional services;

i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.

6. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured patient;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel;
   c. collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

7. A trauma service or multi-disciplinary trauma committee included in their organization which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

8. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.

9. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists:

a. General Surgery
b. Neurologic
c. Obstetric/Gynecologic
d. Ophthalmologic
e. Oral or Maxillofacial or Head/Neck
f. Orthopaedic
g. Plastic
h. Urologic

10. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
    a. Anesthesiology
    b. Emergency Medicine
    c. Internal Medicine
    d. Pathology
    e. Psychiatry
    f. Radiology

11. Commitment by the hospital and its medical staff to treat and care for any patient presenting.

12. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

    a. Immediately Available:
        (1) General surgery:
            A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for trauma patients twenty-four (24) hours per day. A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be promptly available for consultation.

            (Requirement may be fulfilled by a supervised

senior resident as defined in Section A-12 of this Exhibit who is capable of assessing emergent situations. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available:</u>

(1) Cardiothoracic
(2) General Surgeon *(Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second general surgeon.)*
(3) Hand
(4) Neurologic *(Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(5) Obstetric/Gynecologic
(6) Ophthalmic
(7) Oral or Maxillofacial or Head/Neck
(8) Orthopedic
(9) Plastic
(10) Reimplantation/Microsurgery *(This surgical*

service may be provided through a written transfer agreement at Level I and Level II Trauma Centers.)

(11) Urologic

(12) Vascular *(Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

The on-call general surgeon, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;

(b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and

(c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:

Available for consultation or consultation and transfer agreements for adult and pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Pediatric
(3) Spinal cord injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, in-house and immediately available at all times.

(This requirement may be fulfilled by supervised senior residents, as defined in Section A-12 of this Exhibit, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)

b. Promptly Available:
(1) Anesthesiologist

(Shall be Promptly Available with a mechanism

established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(2) Emergency Medicine (Second physician on call.)
(3) Radiologist

c. Available for Consultation:
(1) Cardiologist
(2) Gastroenterologist
(3) Hematologist
(4) Infectious Disease Specialist
(5) Internist
(6) Nephrologist
(7) Neurologist
(8) Pathologist
(9) Pediatrician
(10) Pulmonary Disease Specialist

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**
Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
a. designate a Medical Director;
b. maintain an Emergency Medicine Physician in the Emergency Department twenty-four (24) hours per day;
c. designate an emergency physician to be a member of the trauma team;

d. provide emergency medical services to adult and pediatric patients;
e. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
f. designate a trauma resuscitation area of adequate size to accommodate multi-system injured patient and equipment; and
g. comply with current Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available;
b. appropriate surgical equipment and supplies as determined by the trauma program medical director; and
c. Post Anesthetic Recovery Room (PAR) which meets the requirements of California Administrative Code. (A Surgical Intensive Care Unit is acceptable.)

3. **Intensive Care Service:**

In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, an approved Intensive Care Unit (ICU). The ICU shall:

a. for trauma patients, the ICU's may be separate specialty units;
b. have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
c. have a qualified specialist promptly available to care for the trauma patients in the intensive care unit. (*The qualified specialist may be a resident with two (2) years of training who is supervised*

by the staff intensivist or attending surgeon who participates in all critical decision making.); and

d. the qualified specialist in (3) above shall be a member of the trauma team.

4. **Radiological Service:**

a. The radiological service shall have immediately available a radiological technician capable of performing:
   (1) plain films; and
   (2) computed tomography imaging (CT).

b. A radiological service shall have the following additional services promptly available:
   (1) angiography; and
   (2) ultrasound.

5. **Clinical Laboratory Service:**

A clinical laboratory service shall have:

a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;

b. capability of collecting and storing blood for emergency care; and

c. clinical laboratory services immediately available.

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:

a. Burn Center.
   (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The

Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained and equipped for acute care of the critically injured patient:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities (with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours per day)
   (5) Occupational Therapy Service Speech Therapy Service
   (6) Social Service

2. A trauma center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
      (1) a pediatric intensive care unit approved by the State Department of Health Services' California Children Services (CCS);or pending CCS approval, validation of existing CCS PICU Standards (Attachment A-2) by the County prior to designation as a Pediatric Trauma Center; or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
      (2) a multidisciplinary team to manage child abuse and neglect.
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*

c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
d. An outreach program, to include:
   (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
   (2) trauma prevention for the general public.
e. Written inter-facility transfer agreements with referring and specialty hospitals.

F. QUALITY IMPROVEMENT PROCESS:

Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. VOLUME STANDARDS:

A Level II Trauma Center shall demonstrate the capacity and ability to care for 350 trauma patients annually, including surgical and intensive care unit capacities/capabilities.

H. CLINICAL EDUCATION:

A Level II Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in trauma care. Continuing education in trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.III
PEDIATRIC LEVEL I TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.III
TRAUMA CENTER REQUIREMENTS
PEDIATRIC LEVEL I

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a

period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and

c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is <u>board certified</u> in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A <u>non-board certified</u> physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

(1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal

College of Physicians and Surgeons of Canada;

(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

(3) the physician has successfully completed a residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. GENERAL REQUIREMENTS:

1. A licensed hospital which has been designated as a Level I pediatric Trauma Center by the EMS Agency.

2. ReddiNet System where geographically available.

3. A pediatric trauma program medical director who is a board certified pediatric surgeon (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
   a. recommending pediatric trauma team physician privileges;
   b. working with nursing and administration to support the needs of pediatric trauma patients;
   c. developing pediatric trauma treatment protocols;
   d. determining appropriate equipment and supplies for pediatric trauma care;

e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
f. having authority and accountability for the pediatric trauma quality improvement peer review process;
g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;
h. coordinating pediatric trauma care with other hospital and professional services;
i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.

4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
   c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
   a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
   b. the remainder of the team shall include physician, nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Microsurgery/Reimplantation *(may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service)*
   b. Neurologic
   c. Obstetric/Gynecologic *(may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service)*
   d. Ophthalmologic
   e. Oral or Maxillofacial or Head/Neck
   f. Orthopaedic
   g. Pediatric
   h. Plastic
   i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following <u>non-surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Anesthesiology
   b. Cardiology
   c. Critical Care

d. Emergency Medicine
e. Gastroenterology
f. General Pediatrics
g. Hematology/Oncology
h. Infectious Disease
i. Neonatology
j. Nephrology
k. Neurology
l. Pathology
m. Psychiatry
n. Pulmonology
o. Radiology
p. Rehabilitation/Physical Medicine. (*This requirement may be provided through a written agreement with a pediatric rehabilitation center.*)

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.

11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:
(1) Pediatric Surgeon:
A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for consultation.

(This requirement may be fulfilled by:
(a) a staff pediatric surgeon with experience in pediatric trauma care; or
(b) a staff trauma surgeon with experience in pediatric trauma care; or
(c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
(i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
(ii) a staff pediatric *trauma surgeon with experience in pediatric trauma care or a staff surgeon with experience in pediatric trauma care shall be on-call and promptly available; and*
(iii) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and <u>Promptly Available</u> with pediatric experience:
(1) Cardiothoracic

(2) Pediatric Surgeon *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.)*
(3) Hand
(4) Pediatric Neurologic *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(5) Obstetric/Gynecologic *(This surgical service may be provided through a written transfer agreement.)*
(6) Pediatric Ophthalmic
(7) Pediatric Oral or Maxillofacial or Head/Neck
(8) Pediatric Orthopedic
(9) Plastic Surgeon
(10) Reimplantation/Microsurgery *(This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.)*
(11) Urologic
(12) Vascular *(Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
(b) a staff trauma surgeon or a staff surgeon with experience in trauma care

shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and

(c) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:
(a) a qualified specialist in pediatric emergency medicine; or
(b) a qualified specialist in emergency medicine with pediatric experience; or
(c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education in pediatric emergency medicine with

pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

(i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and

(ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

(2) Pediatric Anesthesiologist:
Pediatric Anesthesiology, Level I shall be immediately available, with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse

anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(3) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

(a) a qualified specialist in pediatric critical care medicine; or

(b) a qualified specialist in anesthesiology with experience in pediatric critical care; or

(c) a qualified surgeon with expertise in pediatric critical care; or

(d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible pediatric critical care physician then:

(i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and

(ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric

intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:
(1) Pediatric Anesthesiology (second call)
(2) Pediatric Emergency Medicine (second call)
(3) Pediatric Gastroenterology
(4) Pediatric Infectious Disease
(5) Pediatric Nephrology
(6) Pediatric Neurology
(7) Pediatric Pulmonology
(8) Pediatric Radiology

c. Available for Consultation:
(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:
(a) General Pediatrics
(b) Mental Health
(c) Neonatology
(d) Pathology
(e) Pediatric Cardiology
(f) Pediatric Hematology/Oncology
(g) Pediatric Infectious Disease

(2) The following qualified specialist with pediatric experience shall be Available for Consultation **or provided through transfer agreement**:
(a) Adolescent Medicine
(b) Child Development
(c) Genetics/Dysmorphology
(d) Neuroradiology
(e) Obstetrics
(f) Pediatric Allergy and Immunology
(g) Pediatric Dentistry
(h) Pediatric Endocrinology
(i) Pediatric Pulmonology
(j) Rehabilitation/Physical Medicine.

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

a. designate an emergency physician to be a member of the pediatric trauma team;
b. provide emergency medical services to pediatric patients;
c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
e. comply with the Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are <u>immediately available</u> unless operating on trauma patients and <u>back-up personnel who are promptly available</u>;
b. appropriate surgical equipment and supplies as determined by the trauma program medical director;
c. cardiopulmonary bypass equipment; and
d. operating microscope.

3. **Pediatric Intensive Care Unit (PICU):**

a. The PICU shall be approved by the State Department of Health Services' California Children Services (CCS), or pending CCS approval, validation of existing CCS PICU Standards by the County prior to designation as a Pediatric Trauma Center;
b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
c. The pediatric intensive care specialist shall be **immediately available**, advised about all patients who may require admission to the PICU, and shall participate in all major therapeutic decisions and

interventions; and

d. The qualified specialist in (c) above shall be a member of the trauma team.

4. **Radiological Service:**

a. The radiological service shall have in-house and immediately available a radiological technician capable of performing:
   (1) plain films; and
   (2) computed tomography imaging (CT).

b. A radiological service shall have the following additional services promptly available for children:
   (1) angiography; and
   (2) ultrasound.

5. **Clinical Laboratory Service:** A clinical laboratory service shall have:

a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;

b. capability of collecting and storing blood for emergency care; and

c. clinical laboratory services immediately available with micro sampling capability.

6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:

a. Burn Center.
   (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a

burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
   (1) Physical Therapy Service
   (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
   (5) Occupational Therapy Service
   (6) Speech Therapy Service
   (7) Social Service

2. A trauma center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code. (Surgical Intensive Care Unit is acceptable.)
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:
      (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
      (2) trauma prevention for the general public; and
      (3) public education and illness/injury prevention education.
   e. Written inter-facility transfer agreements with referring and specialty hospitals.
   f. Suspected child abuse and neglect team (SCAN).
   g. Aeromedical transport plan.

h. Child Life Program.
i. Pediatric Trauma research program.
j. Maintain an educational rotation with an Accreditation Council on Graduate Medical Education (ACGME) approved and affiliated surgical residency program.

F. QUALITY IMPROVEMENT PROCESS:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. CLINICAL EDUCATION AND RESEARCH:

A Level I Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not

limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;
   c. staff allied health personnel;
   d. EMS personnel; and
   e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
PEDIATRIC LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
TRAUMA CENTER REQUIREMENTS
PEDIATRIC LEVEL II

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score " or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

a. responding without delay when notified and requested to respond to the hospital;
b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a

period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and

c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

a. A physician licensed in California who is <u>board certified</u> in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialities for that specialty.

b. A <u>non-board certified</u> physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

(1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal

College of Physicians and Surgeons of Canada;

(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and

(3) the physician has successfully completed a residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient's severity of injury, but must include the trauma surgeon.

B. <u>GENERAL REQUIREMENTS</u>:

1. A licensed hospital which has been designated as a Level II pediatric Trauma Center by the EMS Agency.

2. ReddiNet System where geographically available.

3. A pediatric trauma program medical director who is a board certified surgeon with experience in pediatric trauma care (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
   a. recommending pediatric trauma team physician privileges;
   b. working with nursing and administration to support the needs of pediatric trauma patients;
   c. developing pediatric trauma treatment protocols;
   d. determining appropriate equipment and supplies for

pediatric trauma care;
e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
f. having authority and accountability for the pediatric trauma quality improvement peer review process;
g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;
h. coordinating pediatric trauma care with other hospital and professional services;
i. coordinating with local and State EMS agencies;
j. assisting in the coordination of the budgetary process for the trauma program; and
k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.

4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
   a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
   b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
   c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
   d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.

5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.

6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
   a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
   b. the remainder of the team shall include physician, nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following <u>surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Microsurgery/Reimplantation *(may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service)*
   b. Neurologic
   c. Obstetric/Gynecologic *(may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service)*
   d. Ophthalmologic
   e. Oral or Maxillofacial or Head/Neck
   f. Orthopaedic
   g. Pediatric
   h. Plastic
   i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following <u>non-surgical specialties</u>, which are staffed by qualified specialists with pediatric experience:
   a. Anesthesiology
   b. Cardiology

c. Critical Care
d. Emergency Medicine
e. Gastroenterology
f. General Pediatrics
g. Hematology/Oncology
h. Infectious Disease
i. Neonatology
j. Nephrology
k. Neurology
l. Pathology
m. Psychiatry
n. Pulmonology
o. Radiology
p. Rehabilitation/Physical Medicine (*This requirement may be provided through a written agreement with a pediatric rehabilitation center.)*

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.

11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:
(1) Pediatric Surgeon:
A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for

consultation.

(This requirement may be fulfilled by:
(a) a staff pediatric surgeon with experience in pediatric trauma care; or
(b) a staff trauma surgeon with experience in pediatric trauma care; or
(c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
(i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
(ii) a staff pediatric trauma surgeon with experience in pediatric trauma care or a staff surgeon with experience in pediatric trauma care shall be on-call and promptly available; and
(iii) a staff pediatric trauma surgeon or a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and Promptly Available with pediatric

experience:

(1) Cardiothoracic
(2) Pediatric Surgeon *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.)*
(3) Neurologic *(Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)*
(4) Obstetric/Gynecologic *(This surgical service may be provided through a written transfer agreement.)*
(5) Ophthalmic
(6) Oral or Maxillofacial or Head/Neck
(7) Orthopedic
(8) Plastic
(9) Reimplantation/Microsurgery *(This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.)*
(10) Urologic
(11) Vascular *(Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)*

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

(a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
(b) a staff trauma surgeon or a staff

surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and

(c) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:
Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:
(1) Burns
(2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:
(1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:
(a) a qualified specialist in pediatric emergency medicine; or
(b) a qualified specialist in emergency medicine with pediatric experience; or
(c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education

in pediatric emergency medicine with pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

(i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and

(ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

(2) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

(a) a qualified specialist in pediatric

critical care medicine; or

(b) a qualified specialist in anesthesiology with experience in pediatric critical care; or

(c) a qualified surgeon with expertise in pediatric critical care; or

(d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible pediatric critical care physician then:

(i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and

(ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:

(1) Anesthesiologist:
Anesthesiology, Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists with pediatric experience who

are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(2) Radiologist

c. Available for Consultation:

(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:

(a) General Pediatrics
(b) Mental Health
(c) Neonatology
(d) Pathology
(e) Pediatric Cardiology
(f) Pediatric Gastroenterology
(g) Pediatric Hematology/Oncology
(h) Pediatric Infectious Disease
(i) Pediatric Neurology
(j) Pediatric Radiology

(2) The following qualified specialist with pediatric experience shall be Available for Consultation **or provided through transfer agreement**:

(a) Adolescent Medicine
(b) Child Development
(c) Genetics/Dysmorphology
(d) Neuroradiology
(e) Obstetrics;
(f) Pediatric Allergy and Immunology
(g) Pediatric Dentistry
(h) Pediatric Endocrinology
(i) Pediatric Pulmonology
(j) Rehabilitation/Physical Medicine.

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

a. designate an emergency physician to be a member of the pediatric trauma team;
b. provide emergency medical services to pediatric patients;
c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
e. comply with Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available; and
b. appropriate surgical equipment and supplies as determined by the trauma program medical director.

3. **Pediatric Intensive Care Unit (PICU):**

a. The PICU shall be approved by the State Department of Health Services' California Children Services (CCS), or pending CCS approval, validation of existing CCS PICU Standards by the County prior to designation as a Pediatric Trauma Center;
b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
c. The pediatric intensive care specialist shall be **promptly available** to care for trauma patients in the intensive care unit; and
d. The qualified specialist in (c) above shall be a member of the trauma team.

4. **Radiological Service:**
   a. The radiological service shall have in-house and immediately available a radiological technician capable of performing:
      (1) plain films; and
      (2) computed tomography imaging (CT).
   b. A radiological service shall have the following additional services promptly available for children:
      (1) angiography; and
      (2) ultrasound.

5. **Clinical Laboratory Service:** A clinical laboratory service shall have:
   a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
   b. capability of collecting and storing blood for emergency care; and
   c. clinical laboratory services immediately available with micro sampling capability.

6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
   a. Burn Center.
      (This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The

Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)

b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
   (1) Physical Therapy Service
   (2) Rehabilitation Center (*(This service may be provided through a written transfer agreement with a rehabilitation center.)*
   (3) Respiratory Care Service
   (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
   (5) Occupational Therapy Service
   (6) Speech Therapy Service
   (7) Social Service

2. A trauma center shall have the following services or programs that <u>do not require a license or special permit</u>:
   a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code.(Surgical Intensive Care Unit is acceptable.)
   b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
   c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
   d. An outreach program, to include:
      (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
      (2) trauma prevention for the general public; and
      (3) public education and illness/injury prevention education.
   e. Written inter-facility transfer agreements with referring and specialty hospitals.
   f. Suspected child abuse and neglect team (SCAN).
   g. An aeromedical transport plan.
   h. A Child Life Program.

F. <u>QUALITY IMPROVEMENT PROCESS</u>:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);

2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;

3. Participation in the trauma system data management system;

4. Participation in the local EMS agency trauma evaluation committee;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and

6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. CLINICAL EDUCATION AND RESEARCH:

A Level II Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.

2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:
   a. staff physicians;
   b. staff nurses;

c. staff allied health personnel;
d. EMS personnel; and
e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

Attachment A-1

EMERGENCY DEPARTMENT APPROVED
FOR PEDIATRICS (EDAP) STANDARDS 1999

INTRODUCTION:

These standards were developed as a concerted effort by the Committee on Pediatric Emergency Medicine which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians, National EMSC Resource Alliance, California Chapter 2 of the American Academy of Pediatrics, Emergency Nurses Association, American College of Surgeons, and Los Angeles County Department of Health Services Emergency Medical Services Agency.

These standards have been approved by The Health Care Association of Southern California and meet or exceed Emergency Medical Services for Children (EMSC) administration, personnel, and policy guidelines for the care of pediatric patients in the emergency department set forth by the California Emergency Medical Services Authority in 1995.

DEFINITIONS:

Emergency Department Approved for Pediatrics (EDAP): A licensed basic emergency department that is approved by the County of Los Angeles to receive pediatric patients from the 9-1-1 system. These emergency departments provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies, procedures, and protocols.

Board prepared/eligible: Successful completion of a Board approved emergency medicine or pediatric residency training program.

Promptly available: Being in the emergency department within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, that the interval between the arrival of the patient to the emergency department and the arrival of the respondent should not have a measurably harmful effect on the course of patient management or outcome.

Qualified specialist: A physician licensed in the State of California who has: 1) taken special postgraduate medical training, or has met other specified requirements; and 2) has become board certified within six years of qualification for board certification in the corresponding speciality for those specialities that have board certification and are recognized by the American Board of Medical Specialities.

Senior resident: A physician licensed in the State of California who has completed at least two years of the residency under consideration and has the capability of initiating treatment when the clinical situation demands, and who is in training as a member of the residency program at the designated hospital.

PALS: American Heart Association Pediatric Advanced Life Support Course.

APLS: American Academy of Pediatrics-American College of Emergency Physicians Advanced Pediatric Life Support Course

ENPC: Emergency Nurses Association-Emergency Nursing Pediatric Course

I. ADMINISTRATION/COORDINATION

A. EDAP Medical Director

1. Qualifications:

   a. Qualified specialist in Emergency Medicine or Pediatrics
   b. Completion of eight hours of CME in topics related to pediatrics every two years
   c. Current PALS or APLS provider

2. Responsibilities:

   a. Oversight of EDAP quality improvement (QI) program
   b. Member of hospital emergency department committee and pediatric committee
   c. Liaison with pediatric critical care centers (PCCC), trauma centers, base hospitals, community hospitals, prehospital care

providers, and the EMS Agency.
d. Identify needs and facilitate pediatric education for emergency department physicians
e. Review, approve, and assist in development of all pediatric policies and procedures.

B. Designated Pediatric Consultant *

1. Qualifications: Board certified in pediatrics or having completed the written exam and actively pursuing Board certification in pediatrics.

2. Responsibilities:

a. Member of hospital emergency department committee and pediatric committee
b. Participation with EDAP staff in developing and monitoring pediatric QI program, protocols, and policies and procedures
c. Consult with EDAP Medical Director and Pediatric Liaison Nurse as needed

* Pediatric Consultant may also be EDAP Medical Director

C. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

a. At least two years experience in pediatrics or in an emergency department that sees pediatric patients, within the previous five years.
b. Experience with QI programs is recommended
c. Current PALS or APLS provider or ENPC course
d. Completion of a two day pediatric emergency nursing course*
e. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education units (CEU) in pediatric topics every two years.

* A two day pediatric emergency nursing course should include a broad spectrum of topics including: resuscitation, trauma, medical conditions, near drowning, respiratory distress, ingestion, child abuse and neglect,

fever, seizures, and neonatal emergencies.

2. Responsibilities:

   a. Attend monthly meetings of The Pediatric Liaison Nurses of Los Angeles County.
   b. Participate in development and maintenance of pediatric QI program
   c. Liaison with PCCC's, trauma centers, base hospitals, community hospitals, prehospital care providers, and the EMS Agency.
   d. Member of selected hospital based emergency department and/or pediatric committees.
   e. Notify the EMS Agency in writing of any change in status of the EDAP Medical Director, Pediatric Consultant, and Pediatric Liaison Nurse.

II. PERSONNEL

A. Physicians-Qualifications/Education

1. Twenty four hour emergency department coverage shall be provided or directly supervised by physicians functioning as emergency physicians or pediatricians experienced in emergency care on a full time basis. (96 hours or more per month in an emergency department)* This includes senior residents practicing at their respective hospitals only.

2. At least 75% of the emergency department coverage shall be provided by physicians Board certified or eligible in emergency medicine or pediatrics.

3. Those emergency department physicians who are not board certified or eligible shall be a current PALS or APLS provider.

*May include administrative time.

B. Nurses-Qualifications/Education

1. At least 75% of the total RN staff and at least one RN per shift in the emergency department shall be a current PALS or APLS provider.

2. At least one RN per shift shall have completed a two day pediatric emergency nursing course (within the last 4 years).

   NOTE: It is highly recommended that all nurses regularly assigned to the emergency department meet the above requirements.

3. All nurses assigned to the emergency department shall attend at a minimum, eight hours of pediatric BRN approved education every two years which may include the two day pediatric emergency nursing course.

C. Pediatric physicians/Speciality services

1. Establishment of a pediatric on call panel that allows for telephone consultation and a promptly available pediatrician to the emergency department twenty four hours per day. This pediatrician shall be Board certified or eligible.

2. A plan shall exist whereby other pediatric specialists may be consulted and available in at least the following specialities: surgery, orthopedics, anesthesia and neurosurgery. This requirement may be met by a written agreement with a PCCC.

3. A plan shall exist whereby a second emergency physician or pediatrician will be available within thirty minutes to serve as back-up for the emergency department in critical situations.

III. POLICIES, PROCEDURES, AND PROTOCOLS

A. Establish procedures, and protocols for pediatric emergency patients to include but not limited to:

1. Triage and initial evaluation
2. Patient safety
3. Suspected child abuse and neglect
4. Transfers
5. Consents
6. Conscious sedation

7. Do-not-resuscitate (DNR)
8. Death to include SIDS and the care of the grieving family
9. Aeromedical transport to include landing procedure
10. Daily verification of proper location and functioning of equipment and supplies.
11. Immunizations

B. Establish a written interfacility consult and transfer agreement with a PCCC to facilitate transfers of critically ill and injured pediatric patients and twenty four hour telephone consultation.

C. Establish a written interfacility consult and transfer agreement with a California Children Services (CCS) approved Level II or Level III Neonatal Intensive Care Unit (NICU).

IV. QUALITY IMPROVEMENT (QI)

A. A pediatric QI program shall be developed and monitored by the EDAP Medical Director and Pediatric Liaison Nurse with input from the Designated Pediatric Consultant as needed.

B. The program should include an interface with prehospital care, emergency department, trauma, pediatric critical care, pediatric in-patient, and hospital wide QI activities.

C. A mechanism shall be established to easily identify pediatric (14 years & under) visits to the emergency department.

D. The pediatric QI program should include identification of the indicators, methods to collect data, results and conclusions, recognition of improvement, action(s) taken, assessment of effectiveness of above actions and communication process for participants.

E. The pediatric QI program should include review of the following pediatric patients seen in the emergency department:

1. Deaths
2. Cardiopulmonary and or respiratory arrests,

including all pediatric intubations
3. Suspected child abuse or neglect
4. Transfers to and/or from another facility
5. Admissions from the ED to an adult ward or ICU
6. Selected return visits to the ED
7. Pediatric transports within the 9-1-1 system

F. A mechanism to document and monitor pediatric education of EDAP staff will be established.

V. SUPPORT SERVICES

A. Respiratory Therapy

1. At least one respiratory therapist shall be in house twenty four hours per day.

2. Current PALS or APLS provider

B. Radiology

1. Radiologist on call and promptly available twenty four hour per day

2. Radiology technician in house twenty four hours per day with a second technician on call and promptly available

3. CT scan technician on call and promptly available

C. Laboratory

1. Technician in house twenty four hours per day and a second technician on call and promptly available

2. Clinical Laboratory capabilities in house:

a. Chemistry
b. Hematology
c. Blood bank
d. Arterial blood gas
f. Microbiology
g. Toxicology
h. Drug levels

NOTE: Toxicology and drug levels may be done outside if

routine tests are available within two hours.

VI. EQUIPMENT, SUPPLIES, AND MEDICATIONS

Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. EDAP staff shall be appropriately educated as to the locations of all items. Each EDAP shall have a method of daily verification of proper location and function of equipment and supplies. It is highly recommended that each EDAP have a mobile pediatric crash cart.

The following are requirements for equipment, supplies, and medications for an EDAP:

GENERAL EQUIPMENT:

- Foley catheters (8 - 22fr.)
- IV blood/fluid warmer
- Length and weight tape for determining pediatric resuscitation drug dosages
- Meconium Aspirator
- OB Kit
- Posted or readily available pediatric drug dosage reference material calculated on a dose per kilogram basis
- Restraint device
- Scale
- Warming device

MONITORING EQUIPMENT:

- Blood pressure cuffs (infant, child, adult, and thigh)
- Doppler
- ECG monitor/defibrillator (0-400 Joules) with pediatric and adult paddles
- End tidal $C0_2$ monitor or detector, (adult and pediatric sizes)
- Hypothermia thermometer
- Pulse oximeter

RESPIRATORY EQUIPMENT:

- Bag-valve-mask device, self inflating (pediatric size: 450-900ml and adult size: 1000-2000ml)
- Bag-valve masks, clear (neonate, infant, child, and adult sizes)

- Endotracheal tubes (uncuffed: 2.5-5.5 and cuffed: 6.0-9.0)
- Laryngoscope (curved and straight: 0-3)
- Lubricant (water soluble)
- Magill forceps (pediatric and adult)
- Nasal cannulae (infant, child, and adult)
- Nasopharyngeal airways (infant, child, adult)
- Nasogastric tubes (including 5 and 8fr feeding tubes)
- Oral airways (sizes 0-5)
- Oxygen masks, clear (standard and non-rebreathing) for infant, child, and adult
- Stylets for endotracheal tubes
- Suction catheters (sizes 6-12fr)
- Tracheostomy tubes (sizes 0-6)
- Yankauer suction tips

VASCULAR ACCESS EQUIPMENT:

- Arm boards (infant, child, adult)
- Butterfly needles (19-25ga)
- Central venous catheters (sizes 6-12fr)
- Infusion devices to regulate rate and volume
- Intraosseous needles
- IV administration sets with calibrated chambers
- IV catheters (14-24ga)
- IV solutions (D5.2NS, D5.45NS, D5NS, D10W, and NS)
- Needles (18-27ga)
- Stopcocks (3 way)
- Syringes (TB and 1-60cc)
- T-connectors
- Umbilical vein catheters (may substitute 5fr feeding tube)

FRACTURE MANAGEMENT DEVICES:

- Cervical spine immobilization devices
- Pediatric femur splint
- Spine board (long and short)

SPECIALIZED TRAYS:

- Cricothyrotomy tray
- Pediatric lumbar puncture tray
- Pediatric thoracotomy tray
- Pediatric tracheostomy tray

- Peritoneal lavage tray
- Thoracostomy and chest tube tray (sizes 16-28fr)
- Venous cutdown tray

PEDIATRIC SPECIFIC RESUSCITATION MEDICATIONS:

- Atropine
- Adenosine
- Bretylium
- Calcium chloride
- Dextrose (25% & 50%)
- Dopamine
- Dobutamine
- Epinephrine (1:1000 and 1:10,000)
- Flumazenol
- Lidocaine
- Naloxone
- Racemic epinephrine for inhalation
- Sodium Bicarbonate

Note: It is suggested that these drugs be immediately available in the resuscitation room and not locked in a computerized system.

REVISED

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B (July 2003 -- 2 Year)

PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B (July 2003 -- 2 Year)

PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE INDIGENT TRAUMA CARE

1. GENERAL REIMBURSEMENT CONDITIONS: County has allocated certain monies as set forth herein to be used to pay Contractor for trauma care provided by them to eligible patients during the term of this Agreement. For the term of this Agreement, funds and Hospital Services Account funds shall be deposited to the County administered trust account or Payment Fund referenced in Paragraph 4.B of Exhibit B. These deposits, together with other funds which County may at its sole discretion allocate to the account from time to time, and any interest which the deposits may earn, shall be used to pay Contractor for trauma patient care.

Reimbursement to Contractor shall be provided from the trust account by County for the hospital component of treatment of trauma patients hereunder who are unable to pay for the treatment and for whom payment for such services has not been made and will not be made through private coverage or by any program funded in whole or in part by the Federal government.

Contractor will determine and document persons who are eligible for services coverage hereunder. Only eligible

patients (i.e., (1) those unable to pay for services and (2) for whom third-party payer benefits are either not available or provided) qualify under this funding program. No reimbursement shall be provided for patient care if the patient has the ability to pay for the service, but refuses or fails to pay for same. Nor is County responsible nor shall it pay for services hereunder if Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s). Nor shall reimbursement be due Contractor or paid by County hereunder for any patient care which is covered in, or the subject of reimbursement in, any other contract between Contractor and County.

To bill County, Contractor must at a minimum show that it has made reasonable efforts to secure payment from the patient by billing (at least monthly) for an additional period of not less than two (2) months after the date Contractor first billed the patient. Contractor must show that the person cannot afford to pay for the services provided by the Contractor; and, it must also show that payment for the services will not be covered by third-party coverage or by any program funded in whole or in part by the federal government; and, that Contractor has not received

payment for any portion of the amount billed.

County reimbursement is limited to trauma patients without the ability to pay for the services and for whom Contractor has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment, and there is no source of payment.

Contractor will continue to determine and document persons who are eligible for trauma care coverage hereunder in accordance with the procedures set forth in Attachment "B-1", Trauma Service County Eligibility ("TSCE") Protocol, attached hereto and incorporated herein by reference.

Attachment "U-1", Trauma Service County Eligibility ("TSCE") Agreement form shall be utilized by Contractor as the sole means for determining each patient's eligibility for trauma care coverage during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s). If a TSCE Agreement form cannot be secured because the patient or the patient's responsible relative(s) is (are) unable to cooperate in providing the necessary financial information, then a Contractor certification to that effect (Attachment "U-2", Hospital Certification of Inability to Cooperate form) must be completed. The original of each such form must be maintained by Contractor as part of its financial

records.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request, pursuant to Paragraph 5 of the Additional Provisions Exhibit of this Agreement, to authorized County or State representatives for inspection, audit, and photocopying.

During the term of this Agreement, Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice of the availability of reduced cost hospital care under this Agreement. Additionally, Contractor shall post throughout such period, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced cost hospital care hereunder. The language which must be used in such individual and public notices shall follow that prescribed by the State of California and as it may be revised from time to time. The State's currently approved "Notice" language is reflected in English in Attachment "B-2" and in Spanish in Attachment "B-3".

2. CONTINUED BILLING TO COUNTY: In the event funding as set forth in Paragraph I.4. is exhausted prior to the expiration

or other termination of this Agreement, Contractor shall continue to bill County, for remaining period up to such expiration or earlier termination, in accordance with the terms of this Agreement.

3. PAYMENT FOR CONTRACTOR SERVICES:

A. County agrees under the following conditions to reimburse Contractor for the hospital component of trauma services to eligible trauma patients described in Paragraph 1 of Exhibit B, within forty-five (45) days of receipt of a valid claim:

(1) Reimbursement by County shall be limited to payment for the hospital component of trauma services provided to eligible indigent trauma patients for whom Contractor is required to complete a Trauma Patient Summary ("TPS") form, Attachment "D-2", of Agreement.

(2) Contractor shall submit required reports as set forth in Attachment "B-4", Instructions for Submission of Claims and Data Collection, attached hereto and incorporated herein by reference to County's Emergency Medical Services Agency, 5555 Ferguson Drive, Suite 220, Commerce, California 90022, for trauma care provided under the terms of this Agreement, and this care shall be reimbursed

by County pursuant to subparagraphs I.3.A.(4),(5) and (6).

(3) Reimbursement by County shall be limited to the hospital component of trauma services provided to eligible indigent patients during the term of this Agreement. Reimbursement shall only be made on claims for which all required data is in the TEMIS and which has been submitted as required by reporting procedures reflected in Attachment "B-4". Reimbursement to Contractor and other County contract trauma service hospitals shall be made from the PAYMENT FUND (see infra.). All Contractor claims for reimbursement must be received by County within four (4) months after the close of the fiscal year during which services were provided, no later than the last working day of October for the prior fiscal year.

(4) Following receipt of all of the required reports and billings from Contractor and other contract trauma service hospitals and subject to the funding provision below, County payment hereunder for the hospital component of trauma services provided by Contractor to eligible trauma patients, as defined hereunder, shall be based on

the following all-inclusive rates:

$3,800 per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)

$7,500 for the first inpatient day; and

$3,200 for the second inpatient day; and

$2,500 for the third inpatient day; and

$2,500 for the fourth inpatient day; and

$1,800 for each day thereafter.

These payment will be the maximum amounts payable to Contractor for care hereunder, with aggregate payment for all Contractors for services provided during the term of this Agreement until the funds set forth in Paragraph 3 are exhausted.

(5) Rates for FY 2003-04: For the period from July 1, 2003, to June 30, 2004, 77% of the rates as defined in subparagraph I.3.A.(4) of Exhibit B shall be paid to Contractor.

(6) Rates for FY 2004-05: For the period from July 1, 2004, to June 30, 2005, 100% of the rates as

defined in subparagraph I.3.A.(4) of Exhibit B shall be paid to Contractor.

(7) Once the medical condition of a trauma patient has stabilized, Contractor may contact the County's Medical Alert Center or other personnel as designated by County to request transfer of the trauma patient in accordance with County patient transfer procedures and priority criteria as approved by Director. Until the transfer occurs, County's responsibility for reimbursement to Contractor for medically necessary services shall continue as described herein.

(8) Any and all payments received by Contractor from a trauma patient or from third-party payers, or both, must be immediately reported to County's Expenditure Management Division, 313 North Figueroa Street, Room 531, Los Angeles, California 90012, for disposition.

(9) Director, at his/her discretion, may deduct from payments due to Contractor any prior overpayments made under this Agreement which were paid due to County's or to Contractor's clerical error or which resulted from Contractor's subsequent receipt of payment from the patient or third-party

payer(s). County shall furnish Contractor with an itemization of such deductions, which will include the identity of the patient(s) for whose care overpayment was made, amounts of overpayment, and the basis for the finding of overpayment.

(10) Upon payment to Contractor by County for a trauma patient's care, Contractor shall, within ninety (90) calendar days of payment by County, cease all current and waive all future collection efforts, and County is subrogated to any and all legal and equitable rights and causes of action which Contractor has against such trauma patient, his/her responsible relatives, or third-party payers responsible for the patient's medical expenses, and County may proceed independently, to the extent permitted by law, against such persons or agencies to recover its payment to Contractor. Contractor shall reasonably cooperate with County in these collection efforts.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses.

Except for trauma patients admitted to Contractor prior to or on the last day during th term of this Agreement, and remaining in the hospital after that date, reports and billings to County for patients shall be submitted only after Contractor completes the course of care to the patient (no partial billings). Said reports and billings shall be on forms, and completed in such detail and with such attachments in accordance with procedures prescribed in writing by Director in Attachment "B-4".

Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Said reports shall be submitted to County's Emergency Medical Services Agency no later than within four (4) months after the close of the fiscal year during which services were provided, no later than the last working day of October for the prior fiscal year.

B. All required reports and billings submitted by Contractor shall be rendered in the name of Contractor as said name appears upon the upper portion of the first page of this Agreement.

C. Contractor shall maintain and make available to State

or County representatives upon request records of all of the financial information referenced in this Paragraph, including records of patient and third-party payer payments, all in accordance with Paragraph 5 of the Additional Provisions exhibit of the Agreement.

D. County may periodically conduct an audit of the Contractor's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collection agency reports associated with the sampled claims.

Audited paid claims that do not comply with program requirements shall result in a refund to the County. The dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of adjudicated claims resulting

in a final refund to the County.

Audited claims submitted for which funding is not available and which are determined to be ineligible shall result in a payment to County of 10% of the value of the validated claim as reimbursement for the cost of performing audits and data analysis.

4. FUNDING: The parties have agreed to the following payment mechanisms for payment to the Contractors, with the maximum funding amount as set forth below to apply to the aggregate of payments made to the Contractor under the terms herein, and to payments made to all other trauma hospital Contractors under the terms of identical agreements with the County:

A. (1) Funding for FY 2003-04: County has allocated a maximum total amount of $14.8 million.

(2) Funding for FY 2004-05: Except as set forth below, County has allocated a maximum total amount of $14.8 million. The parties acknowledge that this funding is comprised in part by revenue generated by Measure B, Preservation of Trauma Centers and Emergency Medical Services; Bioterrorism Response annual special tax as allocated by the County Board of Supervisors (Measure B Funds). The parties further acknowledge that the Measure B

Funds may vary based on (1) a percentage change, if any, in the total revenue generated for FY 2004-05 as compared to FY 2003-04 (the base year), and; (2) an adjustment by the cumulative increase, if any, to the medical component of the Western Urban Consumer Price Index from July 1, 2003, as established by the United States Bureau of Labor Statistics if set by the Board of Supervisors, exclusively (Measure B Adjustment). As a result, the total maximum allocation may exceed the aggregate of $14.8 million, taking into account a Measure B Adjustment to the Measure B Funds.

B. Funds shall be deposited to the County contract trauma hospitals trust account and utilized to make payments to all County contract trauma service hospitals at the rates set forth in subparagraphs I.3.A.(4), (5) and (6) of Exhibit B. This account shall be designated the PAYMENT FUND.

C. County contract trauma hospitals shall be paid on a first come, first validated, basis until all funds are disbursed. All funds, including interest, shall be disbursed on or within forty-five (45) days of receipt of validated claims received by County for Contractor

services performed hereunder during the term of this Agreement, all pursuant to the rate schedule identified in subparagraphs I.3.A.(4), (5) and (6) of Exhibit B.

D. "Claims" for purposes of the above means validated claims at the rate defined herein. In no event, however, shall the total disbursement under this Paragraph to Contractor on a claim exceed Contractor's aggregate charges for the services provided (based upon Contractor's customary rates in effect on the dates of service).

E. Maximum amounts payable hereunder to each contractor shall not be modified if, and upon, designation of any other trauma center not a Contractor hereunder.

5. BILLING AND PAYMENT - PHYSICIAN SERVICES: A copy of the revised Trauma Physician Services Program packet for County Fiscal Year 2003-04, Attachment "B-5 ", is attached and incorporated herein by reference. The packet for County Fiscal Year 2004-05 shall be provided to Contractor no later than July 1, 2004, or as soon as reasonably possible thereafter. To permit its physicians to bill County for the professional component of un-reimbursed trauma services furnished to Contractor's trauma patients during the term of this Agreement, Contractor shall furnish members of its physician staff providing such services with a copy of said

packet.

Upon request, Director shall provide Contractor with reports showing total aggregate payments to trauma physicians reimbursed by County for the professional component of un-reimbursed trauma services provided to Contractor during the term of this Agreement.

6. RECOVERY OF PAYMENT: County shall recover monies paid to Contractor hereunder for any of the reasons which follow:

A. If Contractor fails to furnish patient specific data and reports required by this Agreement or by the State, or by both, County shall recover all funds paid to Contractor for that patient.

B. If funds are used for patients deemed ineligible under this Agreement, County shall recover the difference between the amount received and the amount for which Contractor can document that the funds were used only for services for persons who cannot afford to pay for those services and for whom payment will not be fully covered by third-party coverage or by any program funded in whole or in part by the Federal government.

II. FUNDING FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES

1. PRIVATE HOSPITAL FUNDING FOR FY 2003-04: The parties acknowledge that the County is working with the State of California for approval by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), to obtain enhanced Medi-Cal funding in the aggregate amount of $12,378,600 during FY 2003-04 for private hospital Contractors to assure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County. If approved by CMS, the total maximum amount of such enhanced Medi-Cal funding will be allocated to each private hospital Contractor in accordance with the terms, conditions and requirements set forth in a separate agreement to be executed between each Contractor and the State, or its intermediary.

If and upon notification to the County that CMS has disapproved the enhanced Medi-Cal funding proposal, the County shall provide funding in the following maximum amount to each private hospital Contractor to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care during the FY 2003-04 term of this Agreement:

CONTRACTOR	MAXIMUM AMOUNT
Childrens Hospital Los Angeles	$ 249,600
Cedars-Sinai Medical Center	$ 1,563,900

Providence Holy Cross Medical Center	$ 753,350
Huntington Memorial Medical Center	$ 395,200
Henry Mayo Newhall Memorial	$ 205,400
Long Beach Memorial Medical Center	$ 667,550
Northridge Hospital Medical Center	$ 764,400
St. Francis Medical Center	$ 1,124,500
St. Mary Medical Center	$ 465,400

Payment to each private hospital Contractor in the maximum amounts set forth above shall be made in two equal installments on March 31, and June 30, if notice from CMS of disapproval occurs later, as soon after the County's receipt of the notice as reasonably possible.

2. PRIVATE HOSPITAL FUNDING FOR FY 2004-05: The parties acknowledge that the County will work in good faith with the State of California for approval by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), to obtain enhanced Medi-Cal funding in the aggregate amount of $12,378,600 during FY 2004-05 for private hospital Contractors to assure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County. The parties further acknowledge that this aggregate amount is funded in part by the Measure B special tax as described above, and that this

aggregate amount may vary/increase based on a Measure B Adjustment, if any.

If and upon notification to the County that CMS has disapproved the enhanced Medi-Cal funding proposal, the County shall provide funding in the following maximum amount to each private hospital Contractor to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care during the FY 2004-05 term of this Agreement:

CONTRACTOR	MAXIMUM AMOUNT
Childrens Hospital Los Angeles	$ 249,600
Cedars-Sinai Medical Center	$ 1,563,900
Providence Holy Cross Medical Center	$ 753,350
Huntington Memorial Medical Center	$ 395,200
Henry Mayo Newhall Memorial	$ 205,400
Long Beach Memorial Medical Center	$ 667,550
Northridge Hospital Medical Center	$ 764,400
St. Francis Medical Center	$ 1,124,500
St. Mary Medical Center	$ 465,400

(With distribution of any additional funds as a result of a Measure B Adjustment on a pro rata basis.)

Payment to each private hospital Contractor in the maximum amounts set forth above shall be made in two equal installments on March 31, and June 30, if notice from CMS of

disapproval occurs later, as soon after the County's receipt of the notice as reasonably possible. At the sole discretion of the County, payments may be made on a quarterly basis.

3. PUBLIC HOSPITAL FUNDING: To assure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County, the County shall provide funding on an annual basis, for FY 2003-04 and FY 2004-05, in the following maximum amount to each public hospital Contractor:

CONTRACTOR	MAXIMUM AMOUNT
UCLA Medical Center	$ 310,700

Payments to each public hospital Contractor for FY 2003-04 and FY 2004-05 in the maximum amount(s) set forth above shall be made in four equal installments consistent with the dates for payment made to private trauma hospital Contractors as set forth in paragraphs II.1. and 2. of this Exhibit.

4. OTHER PROVISIONS: As a condition of receiving reimbursement as set forth under this section II, Contractor hereby agrees to provide continued and future outpatient emergency room care to Medi-Cal beneficiaries during the term of this Agreement. Should this Agreement be terminated prior to its expiration, Contractor agrees to refund to County on a pro

rata basis any amount paid to Contractor.

Director, at his/her discretion, may deduct from payments due to Contractor under this section II. any prior overpayments made under this Agreement.

III. FUNDING FOR BASE HOSPITAL SERVICES FOR CONTINUED ACCESS TO EMERGENCY CARE FOR MEDI-CAL BENEFICIARIES

1. PRIVATE HOSPITAL FUNDING FOR FY 2003-04: The parties acknowledge that the County is working with the State of California for approval by the United State Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), to obtain enhanced Medi-Cal funding in the aggregate amount of $2,267,751.50 during FY 2003-04 in recognition of the special costs incurred for those Contractors providing base hospital services in support of the trauma system and to ensure continue access Medi-Cal beneficiaries to emergency rooms for emergency care in the County.

If approved by CMS, the total maximum amount of such enhanced Medi-Cal funding will be allocated to each private hospital Contractor in accordance with the terms, conditions and requirements set forth in a separate agreement to be executed between each Contractor and the State, or its

intermediary. The parties acknowledge that Childrens Hospital Los Angeles is not designated as a base hospital.

If and upon notification to the County that CMS has disapproved the enhanced Medi-Cal funding proposal, the County shall provide funding for FY 2003-04 for private hospital Contractors based on call volume for the prior calendar year of service as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 800 calls/month	$ 242,829
Over 800 calls/month	$ 324,311

County has allocated the following maximum amount to be paid to each private hospital Contractor:

CONTRACTOR	MAXIMUM AMOUNT
Cedars-Sinai Medical Center	$ 324,311
Providence Holy Cross Medical Center	$ 242,829
Huntington Memorial Medical Center	$ 242,829
Henry Mayo Newhall Memorial	$ 242,829
Long Beach Memorial Medical Center	$ 242,829
Northridge Hospital Medical Center	$ 242,829
St. Francis Medical Center	$ 324,311
St. Mary Medical Center	$ 242,829

Payment to each private hospital Contractor in the maximum amounts set forth above shall be made in two equal

installments on March 31, and June 30, if notice from CMS of disapproval occurs later, as soon after the County's receipt of the notice as reasonably possible.

2. PRIVATE HOSPITAL FUNDING FOR FY 2004-05: The parties acknowledge that the County is working with the State of California for approval by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), to obtain enhanced Medi-Cal funding in the aggregate amount of $2,267,751.50 during FY 2004-05 in recognition of the special costs incurred for those Contractors providing base hospital services in support of the trauma system and to ensure continue access Medi-Cal beneficiaries to emergency rooms for emergency care in the County. These services shall also assure continued access to Medi-Cal beneficiaries for emergency care by maintaining efficient prehospital transport of all patients to the most appropriate emergency room based on location, the patient's condition and other clinical factors. The parties further acknowledge that this aggregate amount is funded in part by the Measure B special tax as described above, and that this aggregate amount may vary/increase based on a Measure B Adjustment, if any. If approved by CMS, the total maximum amount of such enhanced Medi-Cal funding will be allocated

to each private hospital Contractor in accordance with the terms, conditions and requirements set forth in a separate agreement to be executed between each such Contractor and the State, or its intermediary. The parties acknowledge that Childrens Hospital Los Angeles is not designated as a base hospital.

If and upon notification to the County that CMS has disapproved the enhanced Medi-Cal funding proposal, the County shall provide funding for FY 2004-05 for the private hospital Contractors based on call volume for the prior calendar year of service as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 800 calls/month	$ 242,829
Over 800 calls/month	$ 324,311

County has allocated the following maximum amount to be paid to each private hospital Contractor:

CONTRACTOR	MAXIMUM AMOUNT
Cedars-Sinai Medical Center	$ 324,311
Providence Holy Cross Medical Center	$ 242,829
Huntington Memorial Medical Center	$ 242,829
Henry Mayo Newhall Memorial	$ 242,829
Long Beach Memorial Medical Center	$ 242,829
Northridge Hospital Medical Center	$ 242,829

St. Francis Medical Center	$ 324,311
St. Mary Medical Center	$ 242,829

Payment to each Contractor in the maximum amounts set forth above shall be made in one lump sum.

3. PUBLIC HOSPITAL FUNDING: To assure continued base hospital services for prehospital transport of Medi-Cal beneficiaries to emergency rooms for emergency care in the County and to assure continued access to Medi-Cal beneficiaries for emergency care by maintaining efficient prehospital transport of all patients to the most appropriate emergency room based on location, the County shall provide for each public hospital Contractor on an annual basis, for FY 2003-04 and FY 2004-05, based on call volume for the prior calendar year of service as follows:

CALL VOLUME	MAXIMUM AMOUNT
Up to 800 calls/month	$ 242,829
Over 800 calls/month	$ 324,311

County has allocated the following maximum annual amount for FY 2003-04 and FY 2004-05 to be paid to each public hospital Contractor:

CONTRACTOR	MAXIMUM AMOUNT
UCLA Medical Center	$ 324,311

Payment to each public hospital Contractor for FY 2003-

04 in the maximum amount(s) set forth above shall be made in two equal installments consistent with the dates for payment made to private trauma center Contractors as set forth in paragraph III.1. of this Exhibit. Payment to each public hospital Contractor for FY 2004-05 in the maximum amount(s) set forth above shall be made in one lump sum installment consistent with the date for payment made to private trauma hospital Contractors as set forth in paragraph III.2. of this Exhibit.

4. OTHER PROVISIONS: As a condition of receiving reimbursement as set forth under this section III. Contractor hereby agrees to provide continued and future base hospital services to ensure outpatient emergency room care to Medi-Cal beneficiaries during the term of this Agreement. Should this Agreement be terminated prior to its expiration, Contractor agrees to refund to County on a pro rata basis any amount paid to Contractor.

Director, at his/her discretion, may deduct from payments due to Contractor under this Section III. any prior overpayments made under this Agreement.

Finally, the parties acknowledge State legislation might be enacted now, or in the future, that could increase the registered nurse staffing requirements for base hospitals. In the event the legislation such as this passes during the term of this Agreement, the parties agree to

reopen negotiations with respect to payment for base hospitals.

IV. STATE FUNDING THROUGH THE TRAUMA CARE SERVICES FUND

The parties acknowledge that there exists pending State legislation, to be codified as California Health and Safety Code Section 1797.199.5, which would appropriate from the General Fund to the Trauma Care Funds annually certain monies to be distributed by the State Department of Health Services for distribution to eligible private hospitals designated as Trauma Centers (Trauma Care Funds). To the extent this legislation is passed and the Trauma Care Funds are disbursed to any of the Contractors in this agreement, such disbursement shall not supplant any allocation otherwise provided to such Contractors as set forth in Sections I. through III. of this Exhibit.

TRAUMA SERVICE HOSPITAL AGREEMENT

Attachment B-1

TRAUMA SERVICE COUNTY ELIGIBILITY PROTOCOL

I. PURPOSE: The Trauma Service County Eligibility (TSCE) Protocol is to be used by the County of Los Angeles (County) and by County Contract Trauma Service Hospitals (Contractor) in connection with the Trauma Service Hospital Agreement between the County and Contractor for the purposes of adjusting hospital and other health care charges to Trauma Service Patients for Authorized Services according to the financial conditions of the patient and the patient's responsible relatives.

TSCE shall not in any way diminish or defeat the County's right, under California Government Code Sections 23004.1 and 23004.2 to recover from third-party tort-feasors the reasonable cost of health care services provided to the patients involved.

II. DEFINITIONS:

A. "County Hospital(s)" means any hospital or other health care facility which is owned and operated by the County of Los Angeles.

B. "General Relief recipient(s)" means any person who has been determined eligible for the County's General Relief program as administered by the County Department

of Public Social Services (DPSS).

C. "Inpatient service(s)" means any preventive, diagnostic, or treatment service(s) provided by Contractor to a patient who is a registered inpatient therein.

D. "Inpatient stay of admission " means an uninterrupted term of inpatient services and shall constitute an occurrence of inpatient services.

E. "Emergency Department visit" means any health care services, other than inpatient services, provided in the emergency department by Contractor.

F. "Responsible relative(s)" means the patient's spouse, or parent(s), or legal guardian(s) if the patient is a minor child, or other legal representatives if known.

G. "Special medical payment program(s)" means any program such as Medi-Cal, Medicare, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), California Children Services, and Victims of Crime, which is governed by particular statue, ordinance, or regulation.

H. "Third-party coverage" means any health care benefits payable on behalf of the patient from other than the financial resources of the patient and the patient's

responsible relatives, if any. Generally, third-party coverage includes special medical payment programs, prepaid health plans, and private health insurance.

I. "Trauma Hospital Authorized Service(s)" means any emergency department visits and inpatient services: (1) which have been specifically authorized by the County pursuant to a Trauma Service Hospital Agreement between the County and Contractor, and (2) for which such Contractor may receive reimbursement from the County under such Agreement.

J. "Trauma Patient" means any patient who receives Trauma Hospital Authorized Service.

K. "Trauma Service Hospital(s)" means any hospital or other health facility which is not a County Hospital and which has formally executed a Trauma Service Hospital Agreement with the County under which such hospital or other health care facility may receive reimbursement from the County for Trauma Hospital Authorized Services provided to trauma patients.

III. SERVICES COVERED: TSCE shall cover any occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit) at any Trauma Service Hospital except for any such occurrence of service

for which there is third-party coverage that will fully pay for the particular occurrence of service.

IV. ELIGIBILITY: In order to be eligible for TSCE for inpatient services or for emergency department visits, the patient and the patient's responsible relatives, if any, must cooperate with the County and Contractor in terms of financial data acquisition and otherwise in accordance with TSCE, including, but not necessarily limited to, the following requirements:

A. provide the names and addresses of the patient and the patient's responsible relatives.

B. provide acceptable address verification.

C. complete and sign, under penalty of perjury, the TSCE Agreement, which shall be substantially similar to Attachment U-1, attached hereto and incorporated herein by reference, setting forth, among other things, the income and family size of the patient and the patient's responsible relatives, and the patient's third party coverage, including, but not limited to, prepaid health plan status (member or not). A separate TSCE Agreement shall be completed and signed for each inpatient stay of admission and for each emergency department visit.

D. complete and sign authorization(s) as requested by the

County and the Contractor to allow the County and the Contractor to verify any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

E. provide the County or the Contractor with any documentation requested by the County or the Contractor for any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

V. ELIGIBILITY DETERMINATIONS WHEN PATIENT UNABLE TO COOPERATE: The parties recognize that there may be situations when the patient and/or patient's responsible relatives, if any, are unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make a TSCE determination. Examples of these situations include, but are not necessarily limited to, situations where the patient has expired, or is comatose or otherwise mentally incompetent.

Under these circumstances, the Contractor may certify, under penalty of perjury, that it has endeavored to:

A. obtain the names and addresses of the patient and the patient's responsible relatives;

B. obtain acceptable address verification; and

C. obtain all of the information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and the patient's responsible relatives, and the patient's third-party coverage.

This certification by the Contractor which shall be substantially similar to Attachment U-2, attached hereto and incorporated by reference, shall be accepted by the County in lieu of a TSCE Agreement completed by the patient or patient's responsible relatives.

VI. FREQUENCY OF TSCE DETERMINATIONS: TSCE determination, as to the patient's eligibility for TSCE, shall be subject to the TSCE Agreement (Attachment U-1) and shall establish eligibility for all inpatient services received at a Trauma Service Hospital during an inpatient stay of admission or for health care services received at the said hospital during an emergency department visit.

VII. TSCE ELIGIBILITY COMPUTATION: The patient's TSCE eligibility shall be established by comparing the gross monthly and annual income of the patient and patient's responsible relatives, if any, and the patient's family size to 200 per cent of the Poverty Income Guidelines as published annually in the Federal Register. If the gross monthly and annual

income of the patient and the patient's responsible relatives is less than or equal to 200 per cent of the Poverty Guidelines for the patient's family size, then the patient shall be eligible for TSCE and shall not be liable for the inpatient services received during the particular inpatient stay of admission or for health care services received during the particular emergency department visit.

Any patient who is a verified County General Relief recipient shall automatically by granted TSCE eligibility. Once TSCE eligibility has been established for an occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit), it shall not be re-determined retroactively for any reason except where:

A. The patient and/or the patient's responsible relatives have intentionally failed to fully disclose or have intentionally misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the liability of the patient and the patient's responsible relatives shall, at the election of the Director, revert to the full charge for such occurrence of Trauma Hospital Authorized Service; or

B. Clerical error has occurred or the patient and/or the patient's responsible relatives have negligently failed to fully disclose or have negligently misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the TSCE eligibility shall be re-determined.

C. The patient is determined by the Director not to be eligible as a Trauma Patient for such occurrence of Trauma Hospital Authorized Service, in which case: (1) the patient and the patient's responsible relatives shall not be eligible for TSCE for such occurrence of service, and (2) any funds received by the particular Contractor from the County for such occurrence of service must be repaid to the County. When a patient and/or patient's responsible relatives, if any, previously unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make TSCE determination, agrees to cooperate, TSCE eligibility shall be re-determined.

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

Attachment U-1

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the California Healthcare for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Patient's Responsible Relative(s) _____ Name(s) _____ Addresses(s) _____

_____ - _____ - _____ Social Security Number ( ) _____ - _____ Telephone Number _____/_____/_____ Birthdate

Third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES ☐ NO ☐

TSCE COMPUTATION: (TAKEN FROM 2003 Federal Poverty Level 04/01/03):

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Family Size	Monthly Income	Yearly Income
1	$1,497	$17,964
2	2,020	24,240
3	2,544	30,528
4	3,067	36,804
5	3,590	43,080
6	4,114	49,368
7	4,637	55,644
8	5,160	61,920
9	5,684	68,208
10	6,207	74,484

(For family units with more than 10 members, add $524 monthly and $6,288 yearly for each additional member.)

My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED.

_____ _____/_____/_____
Patient/Responsible Relative(s) Signature Date

_____ _____/_____/_____
TSCE Hospital Reviewer (Required to verify above information and signature.) Date

tsce 040792 Revised csg 06/03

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

Attachment U-2

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for the California Healthcare for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Patient's Responsible Relative(s) _____ Name(s) _____ Addresses(s) _____

_____ - _____ - _____ ( ) _____ - _____ _____/_____/_____
Social Security Number Telephone Number Birthdate

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third party coverage.

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because

_____

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WE WERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

_____ _____/_____/_____
Hospital Reviewer Date

_____ _____/_____/_____
Hospital Supervisor Date

U-2 Revised csg 11/96

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

THIS HEALTH CARE FACILITY IS RECEIVING FUNDING AS A RESULT OF PROPOSITION 99 - THE TOBACCO TAX AND HEALTH PROTECTION ACT OF 1988. THESE FUNDS ARE TO BE USED FOR THE PROVISION OF SERVICES FREE OR AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OR BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (323) 890-7521.

ATTACHMENT B-2

NOTICIA

SERVICIO MEDICO PARA QUIENES NO PUEDEN AFRONTAR PAGARLO

ESTE HOSPITAL ESTA RECIBIENDO FONDOS COMO RESULTADO DE LA PROPOSICION 99 -- IMPUESTO SOBRE EL TABACO Y ACTA DE PROTECCION DE SALUD DE 1988. ESTOS FONDOS SON PARA SER USADOS EN PROVEER SERVICIOS GRATIS O A COSTO REDUCIDO A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.

SI USTED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE NECESITA, USTED TIENE QUE COMUNICARSE CON LA OFICINA DE ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PREGUNTAR ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION, PUEDE LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL COORDINADOR DEL EMS, AL (323) 890-7521.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION

• • • Revised for Fiscal Year 2003/04 • • •

GENERAL INFORMATION

Hospitals must submit both a **CHIP Form** and a **UB-92 Form** for each eligible patient's care if they are claiming reimbursement for Formula Hospital or Trauma Hospital funds under the California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the UB-92 Form are used by the County to comply with State reporting mandates. **An original CHIP Form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all data elements. If, after reasonable efforts are made, some data elements cannot be obtained for services provided as EMERGENCY DEPARTMENT, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or OUTPATIENT/CLINIC VISIT shall not be accepted without completion of all data elements unless a reasonable justification is provided, e.g., "comatose on arrival and expired with no family or identification".**

HOSPITALS--SUBMIT CLAIMS TO:

Department of Health Services
Emergency Medical Services (EMS)
5555 Ferguson Drive, Suite 220
Commerce, California 90022
Attention: HOSPITAL CLAIMS

Contact: Hospital Reimbursement Coordinator - (323) 890-7521

FOR TRAUMA HOSPITALS ONLY

In addition to the following requirements for completion of the CHIP and UB-92 forms, the Trauma Hospital must ensure that all like data elements in the LANCET data system match the CHIP and UB-92 data for trauma patients. Only patients identified in LANCET as "CHIP Eligible" will be considered for payment through the discretionary fund.

COMPLETION OF CHIP FORM

(Only the revised 1/96 CHIP FORM will be accepted for reimbursement)

PATIENT INFORMATION (Items #1-10)

1. TPS#

   Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. SOCIAL SECURITY #

   Enter Patient's social security number. Failure to provide the social security number must be justified in item #20 (REASON) of the CHIP Form.

3. PATIENT'S NAME

   Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

4. PLACE OF BIRTH

   Enter Patient's city, state, and country of birth.

5. MOTHER'S MAIDEN NAME

   Enter Patient's mother's maiden name.

6. ETHNICITY

   Check appropriate box to indicate Patient's racial/ethnic background:

   (1) white
   (2) black
   (3) asian/pacific islander
   (4) native american/eskimo/aleut
   (5) hispanic
   (6) filipino
   (7) other (or none of the above)

7. EMPLOYMENT TYPE

   Check appropriate box to indicate occupation of Patient or Patient's family's primary wage earner:

   (0) unemployed
   (1) farming/forestry/fishing
   (2) laborers/helpers/craft/inspection/repair/production/transportation
   (3) sales/service
   (4) executive/administrative/managerial/professional/technical/related support
   (5) other

8. MONTHLY INCOME

Enter total of Patient's or Patient's family's primary wage earner's wages and salaries (including commissions, tips, and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or workers' compensation, alimony, child support, and any money received from friends or relatives during the previous month by all related family members currently residing in the patient's household.

9. FAMILY SIZE

Enter the number of individuals related by birth, marriage, or adoption who usually share the same place of residence (including any active duty militarymembers who are temporarily away from home). This number includes a head of household who is responsible for payment, and all of this person's dependents. The following members should be included in the family size:

- parent(s)
- children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.
- children under 21 years of age living out of the home but supported by the parent(s), e.g., a child in college

*** Note: **For a minor child, entering one (1) in family size will result in rejection.**

10. SOURCE OF INCOME

Check appropriate box to indicate the primary source (largest single source) of family income:

(0) none
(1) general relief
(2) wages
(3) self-employed
(4) disability
(5) retirement
(6) other, e.g., unemployment/VA benefits/interest/dividends/rent/child support/alimony, etc.

PATIENT INFORMATION VERIFICATION (Items #20-21)

20. REASON(S)

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/CLINIC VISIT, submitting hospital representative is required to enter a reason(s) why information was not obtained and N/A was indicated. All reasonable efforts must be taken to obtain patient information.

*** Note: **N/A will only be accepted for patients seen through the emergency department. Patients admitted to the hospital (INPATIENT) and seen as a doctor's appointment (OUTPATIENT/CLINIC VISIT) shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

21. SIGNATURE

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/CLINIC VISIT, enter a signature of the hospital representative attesting to the fact that every attempt to obtain information was made. If all data elements are complete, a signature is not required.

HOSPITAL SERVICES (Items #11-19)

Hospital services are all inpatient and outpatient services which are medically necessary as certified by the attending physician or other appropriate provider.

11. HOSPITAL AND CODE

Enter Contract Hospital name and three (3) digit alpha code (may be preprinted).

PROVIDER ID

Enter six (6) digit OSHPD number (may be preprinted).

12. HOSPITAL FUND

Check appropriate box to indicate under which fund the claim is being submitted:

(1) formula--hospital has contracted with the County to receive State allocation of CHIP formula funds

(2) contract trauma--trauma hospital has contracted with the County to receive CHIP discretionary hospital funds

13. SERVICE SETTING

Check ONE of the following:

(1) emergency department, CHECK ONE OF: (a) non-emergent visit (b) emergency visit
(2) inpatient
(3) outpatient/clinic visit

*** Note: **Indicate INPATIENT for patient initially assessed and treated in the emergency department and then admitted to the hospital.**

*** Note: **If (1) INPATIENT or (2) OUTPATIENT/OFFICE VISIT is checked, items #2-10 cannot indicate "N/A" (not available) unless a reasonable justification is indicated in item #20 (REASON).**

Definition of emergency services: Emergency services means services provided in the emergency departments of general acute care hospitals for emergency medical conditions.

Definition of emergency medical condition: Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

-- placing the patient's health in serious jeopardy
-- serious impairment of bodily functions
-- serious dysfunction to any bodily organ or part.

14. DATE OF SERVICE/ADMISSION

Enter month, day, and year **of service** (MM/DD/YY) if claim is for an EMERGENCY DEPARTMENT or OUTPATIENT/CLINIC VISIT consistent with #13 above.

Enter month, day, and year **of admission** (MM/DD/YY) if claim is for an INPATIENT (patient admitted to the hospital) consistent with #13 above.

15. DISPOSITION

Check ONE box to indicate the appropriate disposition and enter month, day, and year (MM/DD/YY) of disposition for (1) - (5):

(1) discharge (for inpatient/hospital admissions only)
(2) transfer to County hospital
(3) transfer to non-County hospital
(4) release (for emergency department and outpatient/clinic visits only)
(5) death
(6) still hospitalized (although patient remains hospitalized, claim is being submitted for care provided to date--an alternative is to use the rollover option)

***Note: **For patients transferred to a skilled nursing facility (SNF), regardless if the SNF is on the hospital campus, disposition should be indicated as "discharge".**

16. PAYERS

Enter information regarding any source of payment received for the patient's care.
Specify the source of payment by name and enter the specific amount of payment.
If no payment was made for the patient's care, enter N/A under "Specify Name".

17. DATE BILLED COUNTY

Enter the date hospital submitted the bill to the County.

18. CHARGES

Enter the total amount of hospital charges.

19. CONTACT PERSON AND TELEPHONE NO.

Enter the name of the individual authorized to answer questions regarding the claim, including telephone number.

COMPLETION OF UB-92 FORM

The following UB-92 item numbers must be completed:

1.	Hospital Name
3.	Patient Control Number (Medical Record Number)
12.	Patient's Name (last, first, middle initial)
13.	Patient's Address (street address, city, state, and zip)
14.	Birth Date
15.	Sex
67-77.	Diagnoses (primary and two others, if applicable)
80-81a-e.	Principal and Other Procedures Descriptions, if applicable

6/03

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)

FOR EMS USE ONLY
TRAUMA YES ☐
NO ☐

PATIENT INFORMATION*

COMPLETE ENTIRE CLAIM AND SUBMIT WITH UB-92

1. TPS #: ____
2. SOCIAL SECURITY NUMBER: ☐☐☐ ☐☐ ☐☐☐☐

3. PATIENT'S NAME: _____ (LAST) (FIRST) (MIDDLE INITIAL)

(1) IF MINOR, PARENT/GUARDIAN: _____ (LAST) (FIRST)

4. PLACE OF BIRTH: _____ (CITY) (STATE) (COUNTRY)

5. MOTHER'S MAIDEN NAME: _____

6. ETHNICITY: (CHECK ONE)
- ☐ (1) WHITE
- ☐ (2) BLACK
- ☐ (3) ASIAN/PACIFIC ISLANDER
- ☐ (4) NATIVE AMERICAN//ESKIMO/ALEUT
- ☐ (5) HISPANIC
- ☐ (6) FILIPINO
- ☐ (7) OTHER

7. EMPLOYMENT TYPE:
- ☐ (0) UNEMPLOYED
- ☐ (1) FARMING/FORESTRY/FISHING
- ☐ (2) LABORERS/HELPERS/CRAFT/INSPECTION/ REPAIR/PRODUCTION/TRANSPORTATION
- ☐ (3) SALES/SERVICE
- ☐ (4) EXECUTIVE/ADMINISTRATIVE/MANAGERIAL//PROFESSIONAL/ TECHNICAL/RELATED SUPPORT
- ☐ (5) OTHER

8. MONTHLY INCOME: $ ____
9. FAMILY SIZE (COUNT PATIENT AS 1): ____

10. SOURCE OF INCOME:
- ☐ (0) NONE
- ☐ (1) GENERAL RELIEF
- ☐ (2) WAGES
- ☐ (3) SELF-EMPLOYED
- ☐ (4) DISABILITY
- ☐ (5) RETIREMENT
- ☐ (6) OTHER, , e.g., UNEMPLOYMENT/VA BENEFITS/INTEREST/ DIVIDENDS/RENT/CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

*IF UNABLE TO OBTAIN PATIENT INFORMATION, HOSPITAL REPRESENTATIVE MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

REASON(S): _____ (20)

SIGNATURE: _____ (21)

HOSPITAL SERVICES

11. HOSPITAL: _____ CODE: _____ PROVIDER ID: _____

12. HOSPITAL FUND: ☐ (1) FORMULA ☐ (2) CONTRACT TRAUMA

13. SERVICE SETTING: (1 SETTING ONLY)
- ☐ (1) EMERGENCY DEPARTMENT: ☐ a. NON-EMERGENCY VISIT ☐ b. EMERGENCY VISIT
- ☐ (2) INPATIENT
- ☐ (3) OUTPATIENT/CLINIC VISIT

14. DATE OF SERVICE/ADMISSION (MM/DD/YY): ☐☐☐

15. DISPOSITION:
- ☐ (1) DISCHARGE (INPATIENT ONLY) DATE ☐☐☐
- ☐ (2) TRANSFER TO COUNTY HOSPITAL DATE ☐☐☐
- ☐ (3) TRANSFER TO NON-COUNTY HOSPITAL DATE ☐☐☐
- ☐ (4) RELEASE (EMERG DEPT/OUTPATIENT ONLY) DATE ☐☐☐
- ☐ (5) DEATH DATE ☐☐☐
- ☐ (6) STILL HOSPITALIZED

'AYERS: SPECIFY NAME AMOUNT PAID

PRIVATE INSURANCE: _____ $ ____

OTHER: _____ $ ____

17. DATE BILLED COUNTY: ☐☐☐

18. CHARGES: $ ____

FOR COUNTY USE ONLY AMOUNT DISBURSED $ ____

FOR QUESTIONS REGARDING CLAIM:

19. CONTACT PERSON: _____ TELEPHONE NO: ( ) _____

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

FISCAL YEAR 2003-04
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
BOX 34759
LOS ANGELES, CALIFORNIA 90034-0759

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for trauma services provided by him/her at a County contract trauma hospital to trauma patients who cannot afford to pay, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

Physician acknowledges receipt of a copy of the "Trauma Physician Services Program Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2003/04, the terms and conditions of which are incorporated herein by reference.

In providing eligible trauma services for the full term of fiscal year 2003/04, Physician hereby agrees to abide by the terms and conditions of Billing Procedures, and certifies that he/she will comply fully with the claiming conditions stated therein; and that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

_____
TYPED/PRINTED NAME OF PHYSICIAN

_____ _____
PRIMARY SPECIALTY OF PHYSICIAN SIGNATURE OF PHYSICIAN

_____ _____
STATE LICENSE NUMBER DATE

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2003/04

Completion of Enrollment Form is required annually by each physician

PHYSICIAN NAME: _____ (LAST) _____ (FIRST) _____ (M.I.)

ADDRESS: _____ CITY: _____ ZIP CODE: _____

TELEPHONE NO: ( ) _____ CONTACT PERSON: _____

PRIMARY SPECIALTY: _____ STATE LICENSE NUMBER _____

U.P.I.N.: _____ PAYEE TAX I.D. # _____

PAYEE ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

GROUP NAME: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

COMPANY NAME: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

TELEPHONE NO: ( ) _____ CONTACT PERSON: _____

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY:

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

HOSPITAL NAME: _____ ADDRESS: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents Program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____

SIGNATURE OF PHYSICIAN DATE

MPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS (AIA)
BOX 34759
LOS ANGELES, CA. 90034-0759

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

• • • Revised for Fiscal Year 2003/04 • • •

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Hour Limitation: Reimbursement for emergency services will be limited to the first 48 hours of continuous service and must be provided by a physician on site and in person. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond the 48 hour period.

C. Nonemergent Pediatric and OB Services: Reimbursement may be provided for nonemergency, medically necessary services **ONLY IF** they are provided to a patient who is under 21 years of age (a pediatric patient) or to a pregnant woman from time of conception until ninety (90) calendar days following the end of the month in which the pregnancy ends (an obstetric patient).

D. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will considered upon appeal and/or provision of applicable operative and/or pathology reports.

3. Claims determined to be Medi-Cal eligible will be denied.

E. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency condition exists.

F. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.

G. Pediatric Hospitalization Over Five Days: All claims for pediatric patients hospitalized in excess of five calendar days must be accompanied by a statement from the hospital indicating sources the hospital utilized for reimbursement.

H. Patients 65 years of Age or Older: Unless proof of Medicare denial is provided, e.g., copy of denial of Medicare or Medicare card with Part A only, claims for patients 65 years of age or older will be rejected.

I. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.

III. INELIGIBLE CLAIMS

A. Office Visits: Procedures performed in a physician's office will be denied unless documentation is provided to show that an eligible service was provided to either a pediatric or an obstetric patient. If a claim is made for services provided to an obstetric patient, the expected date of delivery ("EDD") must be included on the CHIP Form (Item #20). An obstetric claim submitted without the EDD will be rejected.

B. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.

C. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.

D. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (i.e., venipuncture). Claims will be reviewed and considered on appeal only.

E. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to "Wet" or "Stat" readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.

B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.

C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.

D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

F. Modifiers: Reimbursement is excluded for all modifiers except radiology.

G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.

H. Critical Care (Codes 99291 and 99292): Reimbursement will not be made on critical care codes after the first 24 hours of service.

I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the CHIP Form, HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
Box 34759
Los Angeles, CA 90034-0759
ATTN: APPEALS UNIT

F\USERS\DPEREZ\AB75\01-02POL.WPD
06/03

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

• • • Revised for Fiscal Year 2003/04 • • •

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, sections 16950 et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth in the "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2003/04", attached as Exhibit "A" and incorporated herein by reference. The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is only valid for trauma services rendered during the period July 1, 2003 through June 30, 2004.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of the trauma hospital.

II. PHYSICIAN ELIGIBILITY

A. The Physician must complete a current fiscal year Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency. A copy of the "Conditions of Participation Agreement" and "Program Enrollment Provider Form" are attached hereto as Exhibit "B" and incorporated herein by reference.

B. Any Physician, **including an emergency department Physician**, who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of the trauma hospital are not, however, eligible for reimbursement under this claiming process.)

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Only patients for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form and who cannot afford to pay for services rendered and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, are covered by this claiming process.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

(a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services.

Upon receipt of payment from the County on a claim hereunder, the Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

If, after receiving payment from the County hereunder, the Physician is reimbursed by a patient or a responsible third party, the Physician shall do one of the following:

(a) immediately notify the County (see address below) in writing and the Physician's future payment of claims hereunder shall be reduced accordingly. In the event there is not a subsequent submission of a claim for County reimbursement hereunder within one year (to which the payment may be applied as credit), the Physician shall reimburse the County in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount received from the County; or

(b) immediately notify the County (see address below) in writing of the payment, and reimburse the County in an amount equal to the amount collected from the patient or third-party payer, but not more that the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:

County of Los Angeles
Department of Health Services

Refund checks should be accompanied by:

-- a copy of the Remittance Advice, and
-- a detailed explanation for the refund, e.g., received a payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:

County of Los Angeles
Department of Health Services
Expenditure Management
313 North Figueroa Street, Room 531
Los Angeles, CA 90012
ATTN: CHIP Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to California Department of Health Services' regulations and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on and after July 1, 2003 and before July 1, 2004. All claims for services provided during the fiscal year 2003/04 (July 1 through June 30) must be received no later than October 31, 2004. Claims received after the fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2004.

VI. REIMBURSEMENT

Except as expressly noted in Paragraph XII, herein below, reimbursement of a valid claim hereunder will be made at 50% of the rate in effect on the date of service, as set forth in the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes in conjunction with the Resource Based Relative Value Scale ("RBRVS") unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $64.14 per relative unit value. The conversion factor for anesthesiology procedures is $39.33 per relative unit value.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2003/04 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators ("AIA")
Box 34759
Los Angeles, CA 90034-0759

B. Complete one HCFA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the contracted Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the contracted Claims Adjudicator at (310) 390-7900, Extension 301.

IX. SUBMIT CLAIM(S) TO COUNTY

American Insurance Administrators (AIA)
P.O. Box 34759
Los Angeles, California 90034-0759
Attention: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within twenty (20) calendar days of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:

AIA Physician Hotline - 1 (800) 303-5242

For Program/Policy Issues, call:

Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies specifically allocated by the State of California under Proposition 99 for this fiscal year. To the extent such monies are available in the County's trauma services sub-account, valid claims presented to the County may be paid. Valid claims will be paid in order of their receipt by the County; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

If there are unexpected and unencumbered monies remaining in the County's trauma services sub-account after all claims submitted by the County's established deadline have been paid, including, any additional payment required by Paragraph VI, County disposition thereof shall be made in accordance with law.

After the County pays the Physician for services billed hereunder, it is understood that the County is subrogated to all rights which the Physician may have against the patient and any third-party payer, and that the County may pursue any such source to recover its expenditures hereunder, using all appropriate means. The Physician shall cooperate with the County in these collection efforts.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. The Physician shall immediately prepare, and thereafter maintain complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and collection revenue, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by the Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the State or County, upon request, at all reasonable times during such three year period for the purpose of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

   Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

   If an audit of the Physician records is conducted by State or County representatives relating to the services for which claim was made and paid hereunder and findings reveal that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) the Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) the Physician did not otherwise

qualify for reimbursement hereunder, the Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude the Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single limit of not less than two million dollars ($2,000,000) per occurrence.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

By utilizing this claiming process, the Physician further certifies that he/she maintains comprehensive auto liability insurance endorsed for all owned, and non-owned vehicles used by him/her and by his/her employees in connection with the professional services for which claim is made, with a combined single limit of at least five hundred thousand dollars ($500,000) per occurence.

C. Non-Discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION

• • • Revised for Fiscal Year 2003/04 • • •

GENERAL INFORMATION

Physicians must submit both a **HCFA-1500 Form** and a **CHIP Form** for each patient's care if they are claiming reimbursement under the County's private physician California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the HCFA-1500 Form are used by the County to comply with State reporting mandates. **An original CHIP form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Physicians are required to make reasonable efforts to collect all data elements; however, Physicians are only required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. If, after reasonable efforts are made, some data elements cannot be obtained, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

MEDI-CAL ELIGIBILITY: Procedures continue to be in place to run all FY 2003/04 claims against the State's Medi-Cal Eligibility Tape. Claims which match both patient and month of service will not be paid by the CHIP program. The physician will be provided with the patient's Medi-Cal number so that the physician can bill Medi-Cal. **ALL CLAIMS should be submitted to American Insurance Administrators.**

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)
P.O. Box 34759
Los Angeles, California 90034-0759
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. Box 34759
Los Angeles, California 90034-0759
Attention: **PSIP CLAIMS**

Contact: AIA Physician Hotline - 1(800) 303-5242

COMPLETION OF CHIP FORM

PATIENT INFORMATION (Items #1-10)

1. TPS #

Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. SOCIAL SECURITY #

Enter Patient's social security number. Failure to provide the social security number must be justified in item # 26 (REASON) of the CHIP Form.

3. PATIENT'S NAME

Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

4. PLACE OF BIRTH

Enter Patient's city, state, and country of birth.

5. MOTHER'S MAIDEN NAME

Enter Patient's mother's maiden name.

6. ETHNICITY

Check appropriate box to indicate Patient's racial/ethnic background:

(1) white
(2) black
(3) asian/pacific islander
(4) native american/eskimo/aleut
(5) hispanic
(6) filipino
(7) other (or none of the above)

7. EMPLOYMENT TYPE

Check appropriate box to indicate occupation of Patient or Patient's family's primary wage earner:

(0) unemployed
(1) farming/forestry/fishing
(2) laborers/helpers/craft/inspection/repair/production/transportation
(3) sales/service
(4) executive/administrative/managerial/professional/technical/related support
(5) other

*** Note: **Employment type must be consistent with required employment information provided on the HCFA-1500. Claims with inconsistent information will be rejected.**

8. MONTHLY INCOME

Enter total of Patient's or Patient's family's primary wage earner's wages and salaries (including commissions, tips, and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or workers' compensation, alimony, child support, and any money received from friends or relatives during the previous month by all related family members currently residing in the patient's household.

9. FAMILY SIZE

Enter the number of individuals related by birth, marriage, or adoption who usually share the same place of residence (including any active duty members of the military who are temporarily away from home). This number includes a head of household who is responsible for payment, and all of this person's dependents. The following family members should be included in the family size:

- parent(s)
- children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.
- children under 21 years of age living out of the home but supported by the parent(s), e.g., a child in college

*** Note: **For a minor child, entering one (1) in family size will result in rejection.**

10. SOURCE OF INCOME

Check appropriate box to indicate the primary source (largest single source) of family income:

(0) none
(1) general relief
(2) wages
(3) self-employed
(4) disability
(5) retirement
(6) other, e.g., unemployment/VA benefits/interest/dividends/rent/child support/alimony, etc.

PATIENT INFORMATION VERIFICATION (Items #26-27)

26. REASON(S)

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, submitting physician/agency is required to enter a reason(s) why information was not obtained and N/A was indicated. All reasonable efforts must be taken to obtain patient information from the hospital.

*** Note: **N/A will only be accepted for patients seen through the emergency department. Patients admitted to the hospital (INPATIENT) and seen as a doctor's appointment (OUTPATIENT/OFFICE VISIT) shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

27. SIGNATURE

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, enter a signature of the physician/submitting agency attesting to the fact that every attempt to obtain information was made. If all data elements are complete, a signature is not required.

PHYSICIAN SERVICES (Items #20-25)

20. PHYSICIAN FUND

Check appropriate box to indicate type of claim being submitted:

(1) **CONTRACT TRAUMA** -trauma care provided at the following hospitals:

Cedars-Sinai Medical Center
Children's Hospital Los Angeles
Henry Mayo Newhall Memorial Hospital
Holy Cross Medical Center
Huntington Memorial Hospital
Memorial Hospital Medical Center of Long Beach
Northridge Hospital Medical Center
St. Francis Medical Center
St. Mary Medical Center
UCLA Medical Center

(2) **NON-CONTRACT EMERGENCY** - all emergency services provided by a licensed Physician excluding specialty care provided by a designated contract trauma hospital as per (1) above.

(3) **PEDIATRICS** - pediatric services means all medical services rendered by any licensed Physician to persons from birth to 21 years of age, and shall include attendance at labor and delivery.

(4) **OBSTETRICS** - obstetric services means the diagnosis of pregnancy and all other medical services provided by a licensed Physician to a pregnant woman during her pregnancy from the time of conception until 90 days following the end of the month in which the pregnancy ends.

*** Note: **If "Obstetrics" is checked, the Expected Date of Delivery (EDD) must be entered.**

21. SERVICE SETTING

Check one of the following:

(1) inpatient
(2) emergency department
(3) outpatient/office visit, CHECK ONE OF: (a) primary care (b) specialty care

*** Note: **If (1) INPATIENT or (2) OUTPATIENT/OFFICE VISIT is checked, items #2-10 cannot indicate "N/A" (not available) unless a reasonable justification is indicated in item #26 (REASON).**

22. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

23. PAYEE NAME, ADDRESS AND TAX ID NUMBER

Enter payee name, address, and nine (9) digit federal tax ID number.

24. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

25. CONTACT PERSON/TELEPHONE NO.

Enter name and telephone number of individual authorized to answer questions regarding the claim.

COMPLETION OF HCFA-1500 FORM

The following HCFA-1500 items must be completed:

Patient's Name (last, first, middle initial)

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

*** Note: **All employment information must be consistent with CHIP Form, item #7(EMPLOYMENT TYPE).**

Hospitalization Dates Related to Current Services (Admission and Discharge dates)

*** Note: **Hospital admit and discharge dates cannot be equal (i.e., 01-01-95 to 01-01-95) unless the patient has expired.**

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The HCFA-1500 section at the top of the form indicating *Medicare, Medicaid, Champus, Group Health Plan, Other,* will only be accepted when *Other* is checked or the section is left blank. If any other box is checked (*Medicare, Medicaid, Group Health Plan, etc.*), the claim will be rejected.

When completing Section Number 24 (A thru K) all lines are to be utilized before going on to another HCFA-1500 form.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)

FOR EMS USE ONLY
TRAUMA YES ☐
NO ☐

PATIENT INFORMATION*

COMPLETE ENTIRE CLAIM AND SUBMIT WITH HCFA-1500

1. TPS #: $

2. SOCIAL SECURITY NUMBER: ☐☐☐ ☐☐ ☐☐☐☐

3. PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

(1) IF MINOR, PARENT/GUARDIAN: _____
LAST FIRST

4. PLACE OF BIRTH: _____
CITY STATE COUNTRY

5. MOTHER'S MAIDEN NAME: _____

6. ETHNICITY: (CHECK ONE)
☐ (1) WHITE
☐ (2) BLACK
☐ (3) ASIAN/PACIFIC ISLANDER
☐ (4) NATIVE AMERICAN/ESKIMO/ALEUT
☐ (5) HISPANIC
☐ (6) FILIPINO
☐ (7) OTHER

7. EMPLOYMENT TYPE:
☐ (0) UNEMPLOYED
☐ (1) FARMING/FORESTRY/FISHING
☐ (2) LABORERS/HELPERS/CRAFT/ INSPECTION/REPAIR/PRODUCTION/ TRANSPORTATION
☐ (3) SALES/SERVICE
☐ (4) EXECUTIVE ADMINISTRATIVE/MANAGERIAL/ PROFESSIONAL/TECHNICAL/RELATED SUPPORT
☐ (5) OTHER

ONTHLY INCOME: $

9. FAMILY SIZE (COUNT PATIENT AS 1): ☐

10. SOURCE OF INCOME:
☐ (0) NONE
☐ (1) GENERAL RELIEF
☐ (2) WAGES
☐ (3) SELF-EMPLOYED
☐ (4) DISABILITY
☐ (5) RETIRED
☐ (6) OTHER, e.g., UNEMPLOYMENT/VA BENEFITS/INTEREST/DIVIDENDS/RENT/ CHILD SUPPORT/ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

*IF UNABLE TO OBTAIN INFORMATION FROM HOSPITAL, SUBMITTING PHYSICIAN/AGENCY MUST GIVE REASON(S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVERY ATTEMPT WAS MADE:

REASON(S): _____
_____ (26)

SIGNATURE: _____ (27)

PHYSICIAN SERVICES

20. PHYSICIAN FUND:
☐ (1) CONTRACT TRAUMA
☐ (2) NON-CONTRACT EMERGENCY
☐ (3) PEDIATRICS
☐ (4) OBSTETRICS EDD: ☐☐☐

21. SERVICE SETTING:
☐ (1) INPATIENT
☐ (2) EMERGENCY DEPARTMENT
☐ (3) OUTPATIENT/OFFICE VISIT, CHECK ONE OF: ☐ a. PRIMARY CARE ☐ b. SPECIALTY CARE

22. PHYSICIAN'S NAME: _____ STATE LICENSE NO: _____

23. PAYEE ADDRESS: _____ PAYEE TAX ID#: _____

PAYEE ADDRESS: _____

24. DATE BILLED COUNTY: ☐☐☐ CHARGES: $

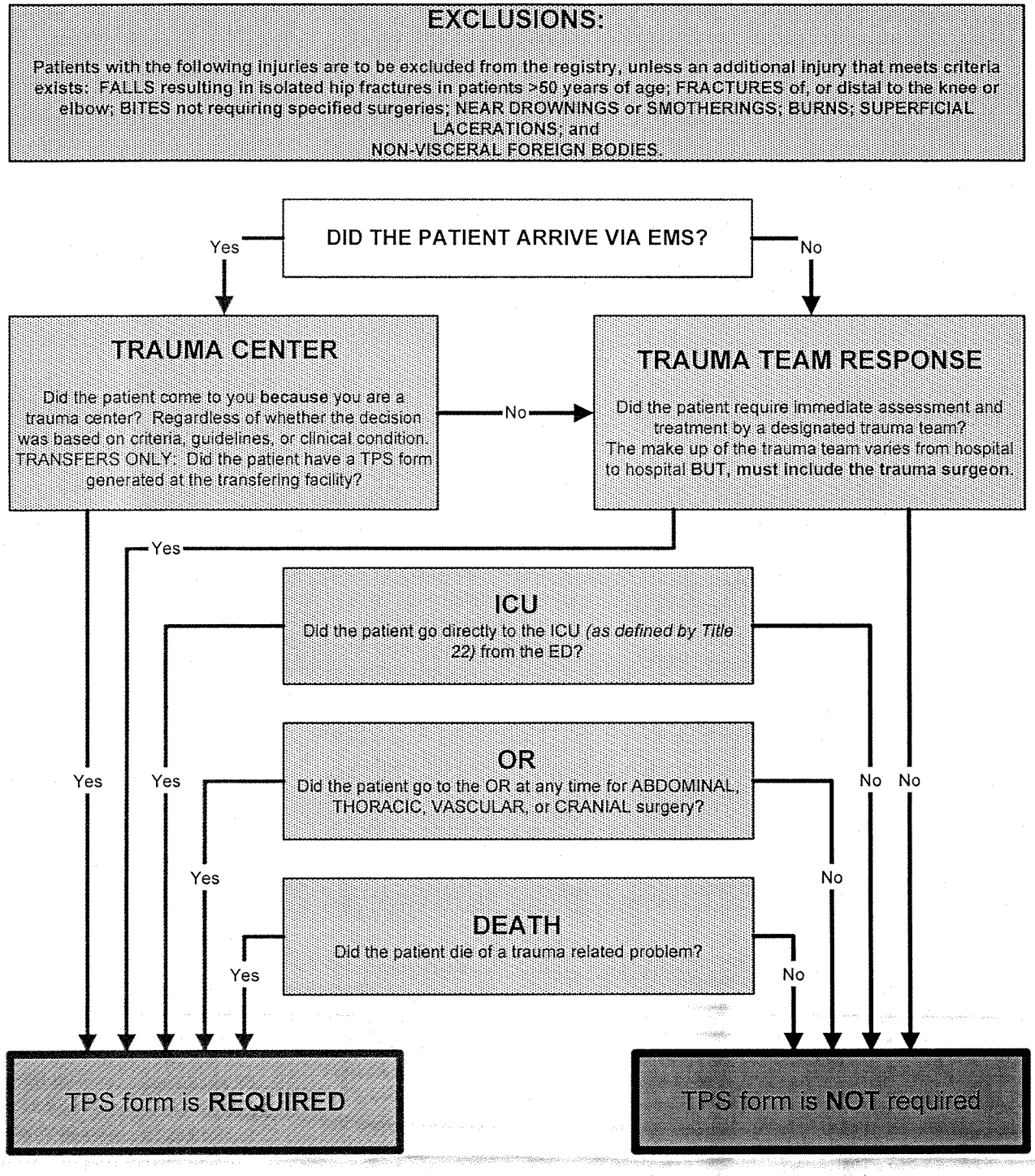
FOR QUESTIONS REGARDING CLAIM:

25. CONTACT PERSON _____ TELEPHONE NO: ( ) _____

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET "EXHIBIT C" CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "OTHER *TRAUMA CENTER* DECISION" INDICATED.

INITIAL PATIENT INFORMATION, (TO INCLUDE PATIENT NAME, ADMIT DATE, MODE OF ENTRY, AND SEQUENCE NUMBER) FROM THE TRAUMA PATEINT SUMMARY PAGE ONE (TPS1) SHALL BE ENTERED INTO THE TEMIS DATABASE WITHIN FIFTEEN (15) DAYS OF HOSPITAL ADMISSION. THE REMAINDER OF TPS1 SHALL BE COMPLETED AND ENTERED INTO THE TEMIS DATABASE WITHIN THIRTY (30) DAYS OF HOSPITAL ADMISSION. TRAUMA PATIENT SUMMARY PAGE TWO (TPS2) SHALL BE COMPLETED AND ENTERED INTO THE TEMIS DATABASE WITHIN SIXTY (60) DAYS OF HOSPITAL DISCHARGE..

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT D

TRAUMA CENTER DATA COLLECTION SYSTEM

1. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY) INCLUDE THE FOLLOWING:

   A. The local EMS agency shall develop and implement a standardized data collection instrument and implement a data management system for trauma care.

      (1) The system shall include the collection of both prehospital and hospital patient care data, as recommended by the Trauma Hospital Advisory Committee (THAC) to the local EMS agency.

      (2) Trauma data shall be integrated into the local EMS agency data management system.

      (3) County commits to pursue the participation, in the local EMS agency data collection system efforts, of all hospitals receiving trauma patients in accordance with local EMS agencies policies and procedures which are based on Title 22.

      (4) County shall generate and distribute periodic reports to all designated Trauma Centers participating in the trauma system on a quarterly basis, to include but not limited to:

         (a) system volume report on the total number of

patients by trauma center; and

(b) system volume report on the number of pediatric patients versus the number of adult patients by trauma center; and

(c) system volume report on the number of blunt injuries versus the number of penetrating injuries by trauma center; and

(d) system volume report on the mechanism of injury by trauma center.

(5) County shall generate and distribute for the purposes of benchmarking to Contractor quarterly reports on system aggregate data on the following:

(a) Intensive Care Unit (ICU) Length of Stay (LOS); and

(b) Payer Source distribution; and

(c) Injury Severity Score (ISS) distribution with the patient's outcome, lived versus died.

(6) County agrees to honor special request for reports by Contractor to compare hospital specific data elements to the system aggregate data elements within a reasonable agreed upon time period.

B. The Department agrees to provide the following to the Contractor:

(1) A current Trauma Center TEMIS software training/procedure manual.

(2) Annually a minimum of sixteen (16) hours Trauma and Emergency Medicine Information System (TEMIS) basic software training and twenty-four (24) hours of intermediate/advanced training will be offered, for all necessary persons identified by Contractor, to enable Contractor personnel to perform data entry, database maintenance, and basic and advanced report generation functions.

(a) Contractor's need for basic training of new employees will be met without regard to the minimum number of participants within two (2) weeks of Contractor's request.

(b) Intermediate/advanced training classes to be scheduled monthly, with a specific agenda for standardized education, with a minimum number of two (2) participants, in no less than four (4) hour increments.

(c) Additional training hours will be made available as needed.

(3) A nonexclusive, nontransferable license to Contractor to use current software and documentation and any software updates, or until Agreement is terminated as set forth herein. Such license also includes the right of Contractor to copy TEMIS software and documentation for back-up

or archive purposes, but such license further gives Contractors no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software or documentation to any other person or entity.

(4) Installation and maintenance of personal computer (PC) peripherals and software meeting specifications shown in Attachment "D-1", TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, for the purpose of Trauma Center data entry and/or data manipulation. The Department will maintain said equipment in fully functioning order until Agreement is terminated or County replaces the equipment. In the event that Agreement is terminated for any reason, the Department shall promptly remove all TEMIS hardware and software and Contractor shall return to County all TEMIS documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

(5) Unlimited technical support for the TEMIS system provided during normal business hours.

C. County does not warrant that operation of the hardware or software will be uninterrupted or error-free. In

the event of a failure, breakdown of the equipment, or errors in software the Department, on behalf of County, shall use reasonable efforts to promptly rectify the software, repair the failure, or replace the defective component. Whenever possible, the Department shall correct a problem in twenty-four (24) hours or less. County shall have no such obligation if the problem(s) is (are) a direct or indirect result of hardware and/or software modifications, or both, made without written approval from Director. County's inability to resolve above issues will result in temporary suspension of Contractor's data obligations.

The foregoing including responsibilities for resolving hardware and software problems are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information and the like), arising out of the use or inability to use the software or hardware, even if County has been advised of the possibility of such

damages.

County does not assume and shall have no liability under this Agreement for failure to repair or replace defective equipment, software, or the corresponding data due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

2. SPECIFIC RESPONSIBILITIES OF CONTRACTOR INCLUDE THE FOLLOWING:

A. Contractor's data collection requirements for patient inclusion in the trauma data base are defined and set forth in Exhibit "C", attached hereto and incorporated herein by reference.

B. Contractor acknowledges receipt of the County Department of Health Services Trauma Patient Summary Form, Attachment "D-2", attached hereto and incorporated herein by reference. Contractor agrees to provide all mandatory data elements from Attachment "D-2" in reporting trauma patient information to the Department, to assist the Department in its data

collection effort. In the event that Director determines that the Department's Trauma Patient Summary Form should be modified or that additional data must be collected by Contractor based on recommendations from the Trauma Hospital Advisory Committee (THAC), said request for additional data must first be referred to the EMSC Data Advisory Committee by Director for review and advice. The Department shall estimate the cost impact on Trauma Centers of the request for the modification and shall advise the EMSC. If the request for additional data results in increased costs to Contractor, Contractor may terminate this Agreement upon giving at least sixty (60) days prior written notice to County.

C. Contractor shall utilize TEMIS application programs and County-owned equipment in a reasonably secure area of the hospital provided by the Contractor. Contractor shall in no way modify the structure or function of the hardware or software without prior written approval of Director. The hardware and software configuration provided shall be used exclusively for the purposes intended herein. Usage for any other purpose or for running any other programs or software shall be done only with the express written consent of Director. Contractors shall at all times provide County

representative(s) designated by Director with reasonable access to Contractor premises to allow installation/maintenance/removal of County-owned property.

D. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software error.

E. If it is reasonably determined by Director that any Contractor repair or replacement of equipment, or repair or recovery of software or data, to the extent deemed feasible by Director, was necessary due to theft or due to Contractor's negligence, Contractor shall reimburse County for the repair, replacement, or recovery cost at a maximum labor rate of Fifty Dollars ($50) per hour, plus the actual cost of parts and materials.

F. Contractor shall provide all supplies necessary for the ongoing use of the County-owned equipment (e.g. printer cartridges, printer paper, floppy diskettes, etc.).

G. Contractor shall seek telephone assistance from

Director, whenever TEMIS operation failure occurs, to obtain County TEMIS maintenance services as described herein.

H. Contractor shall assign qualified back-up personnel to operate TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel during equipment installation.

I. All software application modules, all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Contractor shall use reasonable means to insure that these confidential products are safeguarded and held in confidence. Such means shall include, but not be limited to: requiring each Contractor employee or agent given access thereto to enter into a written agreement in the same form identified as Attachment "D-3", Hospital Employee Acknowledgement and Confidentiality Agreement Regarding Trauma Center Data Collection Obligations, attached hereto and incorporated herein by reference; disclosing confidential County products only to employees with a

need to know of such confidential County products in order for Contractor to exercise its rights and perform its obligation as a Trauma Center; and refraining from reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

J. Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license.

K. Contractor shall safeguard and protect the equipment to ensure full operation. No other application software programs shall be operated on County-owned equipment supplied to Contractor, unless specifically approved in writing by Director.

3. RELEASE AND/OR SALE OF TEMIS DATA:

A. The parties acknowledge that the data collection effort was undertaken for the purpose of improving the Los

Angeles Trauma System and that the County and participating hospitals have expended significant amounts of time, effort and money to develop data collection systems and data. Accordingly, it is hereby acknowledged and agreed that County will not release or sell any identifiable data to any entity for publication or for any other use whatsoever without first receiving written permission from Contractor, if it is identified, except as otherwise provided by law.

B. Only non-hospital identifiable information resulting from the Trauma and Emergency Medicine Information System (TEMIS) may be sold by County without permission of the hospitals.

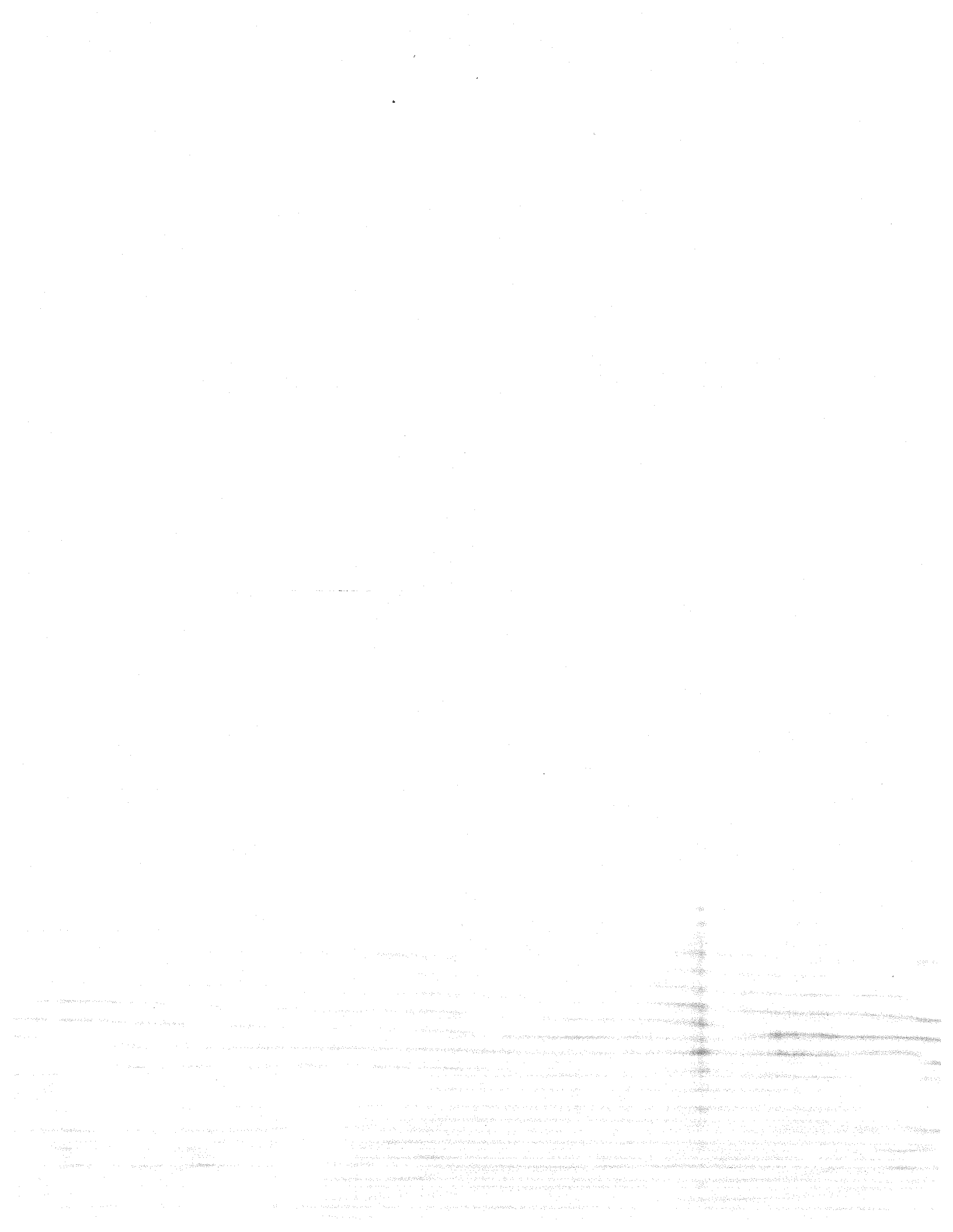
C. Seventy-five percent (75%) of the proceeds of the sale of any TEMIS Trauma Center information shall be distributed to the participating hospitals in equal amounts. Said distribution shall be effected by reducing the annual fee by an amount equal to Contractor's share of the sale of proceeds from the previous year.

TRAUMA SERVICE HOSPITAL AGREEMENT

Attachment D-1

TRAUMA and EMERGENCY MEDICINE INFORMATION SYSTEM (TEMIS)
HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS

Description	Total Quantity
Dell Optiplex GX110 600 MHZ P-III	1
Mid-size Desktop Chassis	1
10/00 Ethernet	1
256K Cache	1
10/20 GB Tape Drive	1
3 Com V90 56K Voice	1
48xCD ROM	1
Audio PCI 64 Voice	1
6.4 Gb EIDE Hard Drive	1
128MB Non-ECC SDRAM 1 DIMM	1
M770 17 inch Monitor	1
4MB Video	1
Space Saver Keyboard	1
Dell Mouse	1
HP LaserJet 2100XI	1
10PPM 4MB 1200DPI PAR IR EIO Slot	1
Windows Client 2000	1
Personal Oracle 8.X	1
PC Anywhere 9.X	1
Norton Antivirus 2000	1
LA Trauma 4.0	1



TRAUMA PATIENT SUMMARY - Page 1

ATTACHMENT D-2

LAST NAME | FIRST NAME | INIT.

ARRIVAL DATE / / Page 1

AGE ____ Yr/Mo/Wk/Day Act/Est DOB____ ETHNICITY White / Black / Nat Amer / Asian-Pac / Hisp / Filip / Unk / Oth

M / F ENTRY MODE EMS: Ground / Air NON-EMS: Police / Vehicle / Other TRANSFER: ED to ED/Direct Admit

MR # | SEQ # | OTHER #

EMS FORM AVAILABLE YES / NO

MANDATORY AB 99 DATA ELEMENTS ARE TO BE ENTERED FROM CHIP FORM

PRE HOSP. & WALK-INS

INJ DATE ___/___/___ PROVIDER ___ ARRIVE SCENE ___ FIELD AIRWAY TYPE:

INJ TIME ___:___ RA/SQUAD # ___ LEAVE SCENE ___ NC / Mask / OP / NP

CR / BVM / ET / ETC

CENSUS TRACT ___ B or P Injury FIELD GCS ___ TRNSFR'D FROM: ___

MECH INJ DESCRIP ___ E ___ INJ MODIFIER: None / Air Bag / Seatbelt / Car Seat: W/ WO Belt / Helmet / Unknown

___ E ___ INJ DESCRIPTION: (See Back) ___

PLACE OF OCCUR ___ E ___ MECHANISM INJ: (See Back) ___

EMERGENCY DEPARTMENT

ED NOTIFIED? YES / NO

TIME NOTIFIED ___

TIME ARRIVED ___

TIME OF EXIT ___

TRAUMA ACTIVATED? YES / NO

LEVEL ___

TIME ACTIVATED ___

MET TRAUMA CRITERIA ? YES / NO

NEXT PHASE AFTER ED:
OPERATING ROOM
ICU
PEDS ICU
STEPDOWN
WARD
PEDS WARD
POSTHOSPITAL:
TRANSFER
HOME
JAIL
MORGUE
AMA

RATIONALE FOR TPS COMPLETION

- ☐ Prehospital Decision *(details optional, right)*
- ☐ Trauma team response
- ☐ Trauma consult response
- ☐ Went to surgery
- ☐ Admitted to ICU
- ☐ Died
- ☐ Transferred to TRAUMA Service
- ☐ Other (DHS = "No" patients)

CRITERIA met:

- ☐ Passenger space intrusion
- ☐ Flail chest
- ☐ Diffuse abdominal tender.
- ☐ Fall >15 ft
- ☐ Blunt Head c GCS = / < 14
- ☐ Spinal cord
- ☐ GSW trunk
- ☐ Penetrating head
- ☐ Penetrating neck
- ☐ Btwn mid clav
- ☐ Low BP - adult
- ☐ Low BP - peds

GUIDELINES met:

- ☐ Surv fatal accident
- ☐ Ejected
- ☐ Very young or old
- ☐ Extrication
- ☐ Ped/Bike vs auto
- ☐ Precarious med hx
- ☐ Prehospital Judgement
- ☐ Other:

MD SERVICES	MD CODE	REQUEST TIME	STAT Y/N	ARRIVAL TIME
TEAM MEMBERS:				
ED MD			Y / N	
TRAUMA SURG			Y / N	
TRAUMA RESID			Y / N	
NEUROSURG			Y / N	
ORTHOPEDIST			Y / N	
ANESTHESIA			Y / N	
ED CONSULTS:				
			Y / N	
			Y / N	
			Y / N	

INITIAL V.S.

TIME ___

BP ___

RR ___

ASST Y / N

HR ___

TEMP: C / F

WEIGHT Kg/lbs.

GCS

EYE	MOTOR	VERBAL
4 = Spontaneous	6 = Obedient	5 = Oriented
3 = To Voice	5 = Localizes	4 = Confused
2 = To Pain	4 = Withdrawal	3 = Inappropriate
1 = None	3 = Flexion	2 = Incomprehensible
	2 = Extension	1 = None
	1 = None	

GCS TOTAL ___

TIME	LABS/XRAY	RESULT ABN/NL
	C-SPINE	A / N
	CT HEAD	A / N
	CXR	A / N
	PELVIS	A / N
	ULTRA SOUND	A / N
	CT ABDOMEN	A / N
	CT CHEST	A / N
	CT SPINE	A / N
	FACIAL SERIES	A / N
	OTHER ___	A / N
	HCT ___	A / N
	ETOH ___	A / N
	TOXICOLOGY SERUM	A / N
	TOXICOLOGY URINE	A / N

PROCEDURE	TIME
☐ ETT/CRIC/TRACH	
☐ ED Thoracotomy	
☐ DPL (Perit. Lavage)	
☐ Chest Tube ☐ Lt ☐ Rt	
☐ CPR Duration: ___ min	
☐ CVP/CENTRAL LINE	
☐ CUT DOWN	
☐ OTHER	

IV FLUIDS

PREHOSPITAL IV FLUIDS ___ cc

ED IV FLUIDS ___ cc

BLOOD PRODUCTS ___ cc

AUTOTRANS ___ cc

Drugs of Abuse: ☐ Amphetamine ☐ Cocaine ☐ Barbiturates ☐ PCP ☐ Cannabinoids ☐ Opiates ☐ Other ___

ED DIAGNOSES	ICD9	ED DIAGNOSES	ICD9

TRAUMA PATIENT SUMMARY - Page 2

ATTACHMENT D-2

ICU

ARRIVAL DATE	EXIT DATE

BLOOD

BLOOD (Total blood/products rec'd during hospital stay - include ED)

BLOOD/PRODUCTS _____ cc

AUTOTRANSFUSER _____ cc

TOTAL Blood/Products _____ cc

NAME	Page 2
ARRIVAL DATE	
MR #	
SEQ #	
OTHER #	

CHECK ALL THAT APPLY
DURING HOSPITAL STAY: ☐ VENTILATOR ☐ CENTRAL LINE ☐ ICP MONITOR ☐ SWAN-GANZ ☐ OTHER _____

OPERATIONS

DATE	CUT TIME	END TIME	MD CODE	SURG TYPE	PROCEDURE	PROCEDURE ICD9

Est. blood loss (cc): (First OR visit from ED ONLY)

NEXT PHASE: Visit 1: Visit 2: Visit 3:

POST HOSP

D/C DATE _____
D/C TIME _____
PRIOR PHASE _____
LIVED / DIED
ORGAN DONATION Y / N

D/C to: Home / Other Hosp / Trauma Ctr / Burn Ctr / Rehab Ctr / SNF / Morgue / Jail / AMA / Other _____

FACILITY NAME [ ][ ][ ][ ] RATIONALE ____ ____

D/C CAPACITY (Not applicable if pt. expired) Pre-Injury Capacity / Temporary Handicap / Permanent Handicap

AUTOPSY by: Coroner / Hospital Coroner # _____ Autopsy Update Y / N

ISCHARGE DIAGNOSES	ICD9	AIS	BODY REGION	DISCHARGE DIAGNOSES	ICD9	AIS	BODY REGION

ISS HAND CALCULATED	1) Head/Neck	2) Face	3) Chest	4) Abd/Pelvis	5) Extremities	6) External	TOTAL ISS:

COMPLICATIONS

☐ Acute Respiratory Distress Syndrome (ARDS)	518.5	☐ Jaundice or Hepatic Failure	782.4	☐ NONE	
☐ Cardiac Arrest (unexpected)	427.5	☐ Pancreatic Fistula	577.8	☐ OTHER _____	
☐ Colonic Anastomotic Leak	997.4	☐ Pneumonia	480.0 - 486.0		
☐ Deep Vein Thrombosis (DVT) (lower extremity) or	451.11 451.19	☐ Pulmonary Embolus (PE)	415.1		
		☐ Renal Failure	584.5, 584.9 or 958.5		
☐ Disseminated Intravascular Coagulation (DIC)	286.6	☐ Septicemia	038.0 - 038.9		
		☐ Surgical Dehiscence/Evisceration	998.3		
☐ Empyema	510.9	☐ Surgical Wound Infection	998.5		
☐ Intra-abdominal abscess	567.2				

CONSULT

DATE	SERV	MD CODE	DATE	SERV	MD CODE	DATE	SERV	MD CODE

FINANCES

List payor in order: 1-3

☐ Cash/Self	☐ Health Plan	☐ Medi-Cal Pending	TOTAL CHARGES
☐ CCS	☐ Group Carrier	☐ Medicare	
☐ CHIP Eligible	☐ HMO	☐ VOC	
☐ CHP/Healthy Families	☐ Medi-Cal HMO	☐ Worker Comp	
☐ Custody Funds	☐ Medi-Cal	☐ Other	$

TRAUMA CENTER SERVICE AGREEMENT

Attachment D-3

HOSPITAL EMPLOYEE
ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT
REGARDING BASE/TRAUMA HOSPITAL DATA COLLECTION OBLIGATION

HOSPITAL : _____

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work associated with my employer's base/trauma hospital data obligations. I agree to forward all requests of the release of any data or information received by me to my employer's TEMIS supervisor.

I agree to keep all hospital, patient, and/or agency identifiable TEMIS data confidential and (unless authorized by the patient or the appropriate agency/hospital CEO) to protect these confidential materials against disclosure to other than my employer or County authorized employees who have a need to know the information.

I agree that all TEMIS software application modules, and all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation, aids, and other items provided to hospital by County for the purposes of the Trauma and Emergency Medicine Information System (TEMIS) data collection shall be considered confidential. As such, I will refrain from reproducing, distributing, or disclosing any such confidential County products except as necessary to perform the Hospital's base/trauma hospital data collection obligation.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of which I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of my employer's data collection obligation or termination of my employment with my employer, whichever occurs first.

I acknowledge that violation of this agreement may subject me to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

NAME: _____ DATE: _____
(Signature)

POSITION: _____

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT E

EMERGENCY MEDICAL SERVICES COMMISSION (EMSC)
DATA ADVISORY COMMITTEE MEMBERSHIP & BY-LAWS

This committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research, and policy development impacting the Trauma & Emergency Medicine Information System (TEMIS).

- Committee to be Chaired by an EMSC Commissioner.
- Two or more EMSC Commissioners appointed to the Committee.
- A base hospital administrator or assistant administrator, or a non administrator duly authorized to represent a base hospital administrator/assistant administrator, selection facilitated by Healthcare Association of Southern California.
- A trauma center administrator or assistant administrator, or a non administrator duly authorized to represent a trauma center administrator/assistant administrator, selection facilitated by Healthcare Association of Southern California.
- A 9-1-1 receiving hospital (non-base/non-trauma) representative, selection facilitated by Healthcare Association of Southern California.
- A public sector paramedic provider representative selected by the Provider Agency Advisory Committee.
- A public sector paramedic provider representative from the Los Angeles County Fire Department.
- A public sector paramedic provider representative from the Los Angeles City Fire Department.
- A private sector paramedic provider representative, selection facilitated by the Ambulance Advisory Board.
- A prehospital care coordinator selected by the Base Hospital Advisory Committee.

- A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee.
- A base hospital medical director selected by the Medical Council.
- A trauma center program director, selection facilitated by the Trauma Committee of the Southern California Chapter of the American College of Surgeons.
- A fire chief, selection facilitated by the Los Angeles County Chapter of the California Fire Chief's Association.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT F

PARAMEDIC BASE HOSPITAL REQUIREMENTS

This Agreement is authorized by Health and Safety Code sections 1797.58 and 1798.100 and Title 22 California Code of Regulations, section 100174. Pursuant to the authority granted under the Emergency Medical Services and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety Code, Sections 1797, et seq.), County maintains an Advanced Life Support ("ALS") system providing services utilizing Emergency Medical Technicians-Paramedics (hereafter "EMT-Ps" or "paramedics") for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general hospital, until care responsibility is assumed by the regular staff of that hospital, and during training within the facilities of a participating general acute care hospital.

1. BASIS AND PURPOSE: The basis of this Agreement is the desire and intention of the parties to cooperate in the operation of each party's component of the paramedic delivery system, consistent with each party's other health services activities and fiscal requirements and the duties and responsibilities of the County. Its purposes are to

establish, in a manner reflective of that cooperative basis, the specific duties and responsibilities of the parties with respect to the matters addressed herein and to provide mechanisms and procedures for the following:

A. resolution of disputes; and

B. communications regarding the operation of the system; and

C. consideration of future development of the system in response to change in circumstances; and

D. interaction with other system participants; and

E. quality improvement.

2. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY): County has designated its Department of Health Services as the local Emergency Medical Services Agency (hereafter "Department", "local EMS Agency", "Agency" or "DHS").

A. The local EMS Agency approves and designates selected paramedic base hospital(s) as the Agency deems necessary to provide immediate medical direction and supervision of paramedics within Los Angeles County in accordance with policies and procedures established by the Agency and State EMS Authority.

B. Policies and Procedures: County shall:

(1) Coordinate the countywide aspects of the ALS system and maintain and operate County components of the PCS.

(2) Establish policies and procedures consistent with State and County laws, regulations, and standards to assure medical control of ALS personnel.

(3) Review and revise policies every three years or as needed.

(4) Distribute to Contractor within sixty (60) calendar days of the execution of this Agreement a complete manual containing all protocols and policies which Agency currently considers to be applicable to participants in the ALS system.

(5) Establish policies and procedures that ensure a mechanism exists for replacing medical supplies and equipment used by advanced life support personnel during treatment of patients. Such policies and procedures shall not require Contractor to provide or replace such medical supplies and equipment.

(6) Establish policies and procedures that ensure a mechanism exists for replacing controlled drugs

and narcotics used by advanced life support personnel during treatment of patients. Such policies and procedures shall not require Contractor to provide or replace such medical supplies and equipment.

C. Interim system re-configuration: DHS may, on an interim basis, restructure the prehospital care system as it deems necessary, including reassignment of MICU's to or from Contractor as the primary directing base hospital, in those instances when a designated base hospital gives notice that it is withdrawing from the system or when a designated base hospital is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, Contractor, if affected by the restructuring, shall be given the immediate opportunity to provide written and oral statements to Director regarding the restructuring to the local EMS Agency and shall be provided with the "due process" procedures specified in Paragraph 16, Due Process, of Exhibit I. Nothing herein, however, is intended to prevent implementation by Director on an emergency basis of such changes as he/she may find measurably necessary to preserve the integrity of the

prehospital care system and to protect the health and safety of County residents.

D. System configuration: Director shall notify Contractor of proposals for substantial operational or structural changes in the components of the ALS system or in the overall operation or configuration of such system. This shall include, but not be limited to, increasing or decreasing the number of base hospitals in the event that a restructuring of the prehospital care system is deemed necessary. In the event the number of base hospitals is increased or decreased, written notice shall be given to Contractor at least thirty (30) calendar days prior to the effective date of any resulting substantial operational or structural changes to the local EMS Agency. If the need for Contractor to serve as a base hospital can no longer be substantiated, or if Contractor is adversely affected by the addition of a new base hospital, Contractor, upon request, shall be provided with "due process" as specified in Paragraph 16, Due Process, of Exhibit I.

E. Data management: DHS, after consultation with and advice from the Emergency Medical Services Commission ("EMSC") Data Advisory Committee, as defined by the EMS

Commission bylaws, if duly constituted, shall continue maintenance of a comprehensive base hospital data collection system. The DHS base hospital data collection system includes:

(1) A base hospital data collection procedure manual.

(2) A minimum of sixteen (16) hours Trauma and Emergency Medicine Information System ("TEMIS") basic software training and up to twenty-four (24) hours of intermediate/advanced training for all necessary persons identified by Contractor, to enable Contractor personnel to perform data entry, database maintenance, and basic report generation functions.

(3) A nonexclusive, nontransferable license to Contractor to use TEMIS software and documentation and any software updates for as long as County maintains its software license contract with Lancet Technology, Inc., or until Agreement is terminated as set forth herein. Such license also includes the right of Contractor to copy TEMIS software and documentation for back-up or archive purposes, but such license further gives Contractor no right to sell, lease, sublease,

donate, assign, distribute, or otherwise transfer any right in TEMIS software or documentation to any other person or entity.

(4) DHS will maintain said equipment in fully functioning order until Agreement is terminated or County replaces the equipment. In the event that Agreement is terminated for any reason, DHS shall promptly remove all TEMIS hardware and software and Contractor shall return to County all TEMIS documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

(5) DHS, on behalf of County, in the event of a failure, breakdown of the equipment, or errors in software, shall use reasonable efforts to promptly rectify the software, repair the failure, or replace the defective component. Whenever possible, DHS shall correct a problem in twenty-four (24) hours or less (excluding Saturday, Sunday, and Holidays). County shall have no such obligation if the problem(s) is (are) a direct or indirect result of hardware or software modifications, or both, made without the

prior written approval from Director.

(6) The foregoing are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information, and the like), arising out of the use or inability to use the software or hardware, even if County has been advised of the possibility of such damages.

(7) County does not warrant that operation of the hardware or software will be uninterrupted or error-free or that all errors will be corrected.

(8) County does not assume and shall have no liability under this Agreement for failure to repair or replace defective equipment, software, or the corresponding data due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not

limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

F. Prehospital care liaison: Director shall designate one or more individuals within the local EMS Agency with the primary responsibilities of reviewing, monitoring, communicating and coordinating matters affecting the ALS delivery system under the jurisdiction of the local EMS Agency. Designated individuals shall periodically attend Contractor's continuing education programs, field care audits, and meetings related to the ALS system and shall perform contract compliance reviews as specified in this Agreement.

G. Assignment of Advanced Life Support Units: After consultation with Contractor and provider organizations, Director shall assign designated ALS units to operate under Contractor's primary control as base hospital. These assignments may be changed from time to time by Director after consultation with Contractor. Director shall take into consideration the

number of base hospital contacts handled by each base hospital within a Base Hospital Region, the receiving hospital for the majority of patients handled by the ALS Unit being assigned, whether the ALS Unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit, and the provider agency's desire to affiliate with a particular base hospital.

H. Paramedic Communication System Management: The Director shall:

(1) Designate one individual within DHS as the PCS manager to provide administration and direction of the PCS.

(2) Utilize County's Internal Services Department ("ISD") for ongoing design, installation, maintenance, and technical consultation.

(3) Assign Hospital frequencies and private line ("PL") tones in consultation with ISD.

(4) Notify Contractor of any proposals for operational or structural changes in the components of the PCS. No substantial operational or structural change in the components of the PCS will be made without prior notification of Contractor, and until Contractor, if it wishes, has appropriately

exhausted administrative due process remedies under this Agreement.

(5) Promulgate PCS communications operations procedures and maintenance standards in cooperation with ISD prior to the execution of this Agreement. Any changes made during the term of this Agreement shall be reviewed and approved by the Communications Management Committee, described in Attachment "F-1", attached hereto and incorporated herein by reference.

(6) Notify the Healthcare Association of Southern California ("HASC") of any proposals for changes in policies and procedures.

3. RESPONSIBILITIES OF INTERNAL SERVICES DEPARTMENT:

A. Assume ongoing responsibility for the design, development, timely implementation, and technical integrity of the PCS. To the extent feasible, ISD shall consult with the DHS PCS Manager and solicit input in the areas of design development, implementation, and technical integrity of the PCS.

B. Maintain and repair County-owned equipment.

C. Prepare PCS communications operating procedures and maintenance standards in cooperation with the local EMS

Agency.

4. RESPONSIBILITIES OF CONTRACTOR:

A. General Requirements:

(1) Be licensed by the State Department of Health Services ("SDHS") as a general acute care hospital.

(2) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

(3) Have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5, California Code of Regulations.

(4) Unless exempted in writing by the Medical Director of the local EMS Agency, meet or exceed standards for Emergency Departments Approved for Pediatrics ("EDAP").

(5) Satisfy the requirements of Title 22, California Code of Regulations, section 100174.

(6) Participate in the ReddiNet communication system.

B. Standards and Protocols: Contractor shall implement and monitor the policies and procedures of the local EMS Agency for medical direction of prehospital care

advanced life support personnel.

C. Data Collection Requirements:

(1) Contractor shall complete and submit a Base Hospital Form for every base hospital paramedic contact involving a patient to Director, the completion and submission of which shall be according to DHS procedure and formats previously provided to Contractor. One form shall be completed for every ALS patient involved in an incident. A sample of the DHS approved Base Hospital Form, Attachment "F-2", is attached hereto and incorporated herein by reference. Contractor shall submit the Base Hospital Form within thirty-five (35) calendar days of its completion. Upon approval of Director, Contractor may discontinue transmittal of a "hard copy" of the form when Director determines that the computer data base hospital form information which is transmitted to Agency is of high quality and timely, and reflects all documentation.

(2) Receiving Hospital Outcome Data: Contractor shall complete emergency department outcome data for all patients where Contractor provided base hospital

medical direction to prehospital care personnel and patients were delivered to its emergency department via the County's prehospital care system. Contractor personnel shall enter the information as defined in Receiving Hospital Outcome Data, Attachment "F-3", attached hereto and incorporated herein by reference, onto the Base Hospital Form and into the County's automated data collection system (TEMIS).

(3) In the event the County determines that existing forms, logs, and documents should be modified or that additional data needs to be collected from Contractor, said modification or request for additional data must first be reviewed by the EMSC Data Advisory Committee. County shall estimate the cost impact on Contractor of the proposed modification or request for additional data, and, if a dispute concerning same arises, the matter may be submitted to the EMSC for arbitration in accordance with County Code section 3.20.070.

(4) Contractor shall submit required data under County's automated data collection system to Agency via Agency defined media within thirty (30)

calendar days following an "incident" according to procedures identified in Agency "TEMIS Users Manual", incorporated herein by reference. A copy of the TEMIS Users Manual has previously been provided to Contractor. Data format must meet specifications defined by Agency. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software errors.

(5) Contractor shall utilize TEMIS application programs and County-owned equipment provided Contractor in TEMIS Hospital Hardware and Software Specifications, Attachment "F-4", attached hereto and incorporated herein by reference. Contractor shall in no way modify the structure or function of the hardware or software without the prior written approval of Director. The hardware and software configuration provided shall be used

exclusively for the purposes intended herein. Usage for any other purpose or for running any other programs or software shall be done only with the express written consent of Director. Contractor shall at all times provide County representative(s) designated by Director with reasonable access to Contractor premises to allow installation/maintenance/removal of County-owned property.

(6) If it is reasonably determined by Director that any Contractor repair or replacement of equipment, or repair or recovery of software or data, to the extent deemed feasible by Director, was necessary due to theft or due to Contractor's negligence, Contractor shall reimburse County for the repair, replacement, or recovery cost at a maximum labor rate of $ 100.00 per hour, plus the actual cost of parts and materials. Contractor shall provide all supplies necessary for the ongoing use of the County-owned equipment (e.g. printer cartridges, printer paper, floppy diskettes, etc.).

(7) Contractor shall seek telephone assistance from Director, whenever TEMIS operation failure occurs,

to obtain County TEMIS maintenance services as described herein.

(8) Contractor shall assign qualified back-up personnel to operate TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel. Arrangements for training of new or replacement Contractor personnel, shall be the primary responsibility of Contractor.

(9) All software application modules, all modifications, enhancements, and revisions thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Contractor shall use reasonable means to insure that these confidential data system products are safeguarded and held in confidence. Such means shall include, but not be limited to: requiring each Contractor employee or agent given access thereto to enter into a written

agreement in the same form identified as Attachment "F-5", Hospital Employee Acknowledgment and Confidentiality Agreement, attached hereto and incorporated herein by reference; disclosing confidential County data system products only to employees with a need to know of such confidential County data system products in order for Contractor to exercise its rights and perform its obligation as a base hospital; and refraining from reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County data system products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

(10) Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse

of the software license by Contractor or Contractor personnel.

(11) Contractor shall safeguard and protect the equipment to ensure full operation. No other application software programs shall be operated on County-owned equipment supplied to Contractor, unless specifically approved in writing by Director.

(12) Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor costs associated with providing ALS services, including data collection. Nothing herein, however, requires reimbursement or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray such costs.

D. Availability of Records: Contractor shall submit copies of all records, tapes, and logs pertaining to prehospital care of patients and personnel involved in the prehospital care system at the request of representatives of Agency. Records obtained from

Contractor may be used for, but are not limited to, audit, investigation, or statistical analysis. Representatives of the local EMS Agency shall comply with all applicable State and Federal laws relating to confidentiality and shall maintain the confidentiality of all records, tapes, and logs submitted in compliance with this subparagraph in accordance with the customary standards and practices of government third-party payers.

E. Advanced Life Support Program Monitoring: Contractor extends to Director and to authorized representatives of the State, the right to review and monitor Contractor's programs and procedures with respect to this Agreement, and to inspect its facilities for contractual compliance with State and local EMS Agency policies and regulations. Inspections by DHS staff shall be conducted during County's normal business hours and only after Director has given Contractor at least three (3) working days prior written notice thereof. In computing the three working days, a Saturday, Sunday, or legal holiday shall not be included. Entry and exit conferences shall be held with Contractor's Administrator or his or her designee.

Said notice need not be given where Director determines that the health and welfare of patients may be jeopardized by waiting the three day period.

F. Audit/Compliance Review: Contractor shall permit audits and reviews of prehospital care records by representatives of Agency upon request to assure compliance with State and local EMS agency policies and regulations. Contractor shall be given no less than thirty (30) calendar days notice in advance of said review. Contractor's director of utilization review and director of medical records shall be permitted to participate in the review and Contractor and its staff shall fully cooperate with County representatives. In the conduct of such audit and review, Contractor shall allow such representatives access to all reports, tapes, medical records, and other reports pertaining to this Agreement, and shall allow photocopies to be made of these documents, utilizing Contractor's photocopier.

Records of Contractor or its medical review committees having responsibility for evaluation and improvement of the quality of care rendered in a hospital, and which are protected by Evidence Code section 1157, are not subject to review.

An exit conference shall be held following the performance of such an on-site compliance review by Director and results of the compliance review shall be discussed with Contractor's Administrator or his or her authorized designee prior to the generation of any final written report or action by Director or other DHS representatives based on such review. The exit conference shall be held on site prior to the departure of the reviewers and Contractor shall be provided with an oral or written list of preliminary findings at the exit conference. If a written report of the audit or compliance review is prepared, Contractor shall be provided with a copy thereof prior to its public release or referral of the report to any other public agency. Contractor shall permit periodic unscheduled site visits by Agency representatives for monitoring ED diversion status, continuing education programs, and prehospital care meetings.

G. Record Retention:

(1) Contractor shall retain the receiving hospital copy of the EMS Report Form for a minimum of seven (7) years and include such reports with patient charts for patients brought to Contractor as part

of the ALS system. Such records, if for a minor, shall be retained for a minimum of seven (7) years, or, if for a minor, one (1) year past the age of majority, whichever is greater.

(2) Contractor shall retain all tapes (not transcriptions), logs, and base hospital forms for a minimum of seven (7) years. If such records are for a minor, they shall be retained for a minimum of seven (7) years, or one (1) year past the age of majority, whichever is greater.

(3) Contractor shall retain all records related to suspected or pending litigation until completion and resolution of all issues arising therefrom.

H. Communication Between Base Hospital and Receiving Hospital:

(1) Contractor shall communicate all appropriate ALS patient management information to the receiving hospital to which a patient is directed as the result of a radio or telephone communications response. Such notification shall be by commercial telephone and conveyed by a physician or MICN familiar with the treatment given, as soon as the patient destination is determined, or as

soon as is practically possible.

(2) Contractor shall assist newly approved Standing Field Treatment Protocol (SFTP) paramedic providers to utilize SFTPs in determining patient destination and in notifying the receiving hospital, for up to two (2) years after SFTP implementation or until such time paramedic providers are capable of so notifying the receiving hospital, whichever is less.

I. Reimbursement for Advanced Life Support Direction:

(1) Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions or other payments from municipalities, paramedic provider agencies, or receiving hospitals to defray costs associated with providing ALS services, including supply and resupply of ALS unit. Except as expressly noted, nothing herein, however, requires reimbursement or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray such Contractor costs.

J. Base Hospital Assignment of Advanced Life Support Units: Except as otherwise may be noted herein, the

number of ALS units assigned to Contractor on a primary basis shall be based upon the number of base hospital contacts handled by each base hospital within a geographic area; the receiving hospital for the majority of patients handled by the ALS units being assigned; whether a base hospital within the geographic area can reasonably accept an/any additional unit/s; whether the ALS unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit; and the provider agency's desire to affiliate with a particular base hospital. Subject to Paragraph 16, Due Process, nothing herein, however, shall be deemed to restrict Director and County's Board of Supervisors in the exercise of their authority under applicable laws and regulations to designate additional base hospitals within the geographic area served by Contractor hereunder.

K. Continuing Education:

(1) Contractor shall provide formal education programs (including lectures/seminars, field care audits, and supervised clinical experience) for licensed paramedics, paramedic interns, and Certified Mobile Intensive Care Nurses (MICNs) in accordance

with policies established in the Prehospital Care Policy Manual by Director. County requirements for such programs shall be an accumulative average of (4) hours of education per month, of which an average of two (2) hours per month are field care audits. Contractor shall also ensure a mechanism for providing and evaluating clinical experience each month as needed. These formal education programs, including the number of required hours, may be done in collaboration with education provided directly by the assigned provider agency or other base hospitals.

(2) Contractor shall facilitate scheduling required field experience for MICN certification.

(3) In addition, Contractor shall provide special and mandatory training programs deemed necessary in writing by Director. A minimum of three (3) mandatory classes shall be given and scheduled so as to provide continuing education of the majority of the ALS units assigned to Contractor.

(4) Contractor shall provide supervised clinical experience for paramedic interns in accordance with State and Agency policies and procedures,

upon request of a Los Angeles County approved training school that has a signed Clinical Agreement with Contractor.

(5) Contractor shall coordinate a prehospital orientation program for new base hospital physicians and nursing staff to the prehospital program. To the extent Contractor is required to provide mandatory formal education programs over and above those set forth in subparagraphs (1) and (2) immediately above, Contractor may seek reimbursement, contributions, or other payment to defray its costs from municipalities, paramedic provider agencies, or receiving hospitals. However, nothing herein shall be deemed to require any such reimbursement, contribution, or payment.

L. Hospital Minutes/Attendance Rosters: Contractor shall routinely record minutes of all base hospital meetings, and maintain attendance records of all such meetings, and continuing education classes. Contractor shall forward copies of base hospital meeting minutes to the Agency's Prehospital Care section on a regular basis, but no less than quarterly. Contractor shall forward the following to Agency:

(1) Copies of base hospital meeting minutes to the Prehospital Care Program Office.

(2) Monthly continuing education schedules to the Office of Program Approvals.

(3) Yearly summaries of classes including the date, course title, category, and number of continuing education hours to the Office of Program Approvals by January 31 of the following year.

(4) Los Angeles County mandated course rosters to the Office of Prehospital Certification no later than fifteen (15) calender days, after the class concludes, but not to exceed established deadline of course.

M. Base Hospital Medical Director: Contractor shall designate an emergency physician to direct and coordinate the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Contractor, and to ensure compliance with policies, procedures, and protocols established by the Agency. This physician, who shall have the title of "Base Hospital Medical Director", shall:

(1) Be board certified in Emergency Medicine.

(2) Be engaged at hospital in the field of emergency medicine as a full-time emergency physician, as defined by spending an average of at least ninety-six (96) hours per month in the practice of emergency medicine and have experience and knowledge of base hospital radio operations and local EMS Agency policies and procedures. The number of prescribed hours may include administrative and or educational hours spent in meeting Base Hospital Medical Director responsibilities.

(3) Comply with the provisions set forth in the Prehospital Care Policy Manual.

(4) Satisfactorily complete orientation to hospital's prehospital care program.

(5) Attend a mandatory EMS orientation course as provided for by the Agency within six (6) months of assuming Base Hospital Medical Director responsibilities.

(6) Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or

receiving hospitals to defray Contractor's costs associated with providing ALS services, including the Base Hospital Medical Director's salary. However, nothing in this Agreement shall be deemed to require any such reimbursement, contribution, or other payment.

N. Base Hospital Physicians: Contractor shall have at least one (1) full-time emergency department physician on duty at all times. Such emergency department physician shall be responsible for prehospital management of patient care and patient destination. If a paramedic run is not handled directly by the base hospital physician, such physician shall be immediately available for consultation by an MICN directing a paramedic run. All of Contractor's emergency department physicians participating in Contractor's activities as a base hospital shall:

(1) Satisfactorily complete Contractor's base hospital orientation program. Such a program shall include: base hospital protocols, base hospital treatment guidelines, base hospital radio operations, and prehospital medicine approved by the Medical Director of Agency, within thirty (30)

days of assuming base physician responsibilities.

(2) Be board certified in Emergency Medicine or have satisfied the requirements to take the emergency medical board examination, or have completed the Advanced Cardiac Life Support provider training program within a reasonable time, not to exceed ninety (90) calendar days from the date of assignment to Contractor.

(3) Comply with policies and procedures of the local EMS Agency.

(4) Be under the direction of the Base Hospital Medical Director.

O. Mobil Intensive Care Nurses (MICNs): MICNs, when utilized by the base hospital to assist base hospital physicians in medical control and supervision of prehospital care, shall:

(1) Be currently certified as an MICN in Los Angeles County.

(2) Be currently certified as an Advanced Cardiac Life Support provider or instructor.

(3) Comply with policies and procedures of the local EMS Agency.

(4) Be under the direction of the base hospital

physician on duty.

(5) Be employed by one of the following agencies approved to employ and utilize MICNs in Los Angeles County:

a. Base hospital

b. EMS Agency

c. Paramedic training program

d. Paramedic provider agency

P. Prehospital Care Coordinator ("PCC"): Contractor shall designate an MICN with experience and knowledge of base hospital radio operations and local EMS Agency policies and regulations to serve as the Contractor's PCC and as a liaison to the local EMS Agency, paramedic provider agencies, and the local receiving facilities. Under the direction of, and in conjunction with the Contractor's Base Hospital Medical Director, the PCC shall be a full time equivalent (FTE) and be dedicated to assisting in the direction and coordination of the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Contractor and shall ensure compliance with policies, procedures, and protocols established by the Agency. The PCC shall:

(1) Be currently certified as an MICN in Los Angeles County.

(2) Have experience in, and knowledge of, base hospital radio operations and Agency policies, procedures, and protocols.

(3) BE available during normal County business hours to meet the responsibilities set forth in this subparagraph.

(4) Comply with the provisions set forth in the Prehospital Care Policy Manual.

(5) Attend a mandatory EMS orientation course as provided for by the Agency within six (6) months of assuming base hospital PCC responsibilities.

(6) Nothing in this Agreement shall prohibit Contractor from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Contractor's costs associated with providing ALS services, including the PCCs salary. Nothing, however, in this Agreement shall be deemed to require any such reimbursement, contributions, or other payments.

Q. Agency Notification of Hiring/Termination of Mobil

Intensive Care Nurses: Contractor shall notify the Agency's Office of Prehospital Certification within fifteen (15) working days of the hiring or termination of any MICN as well as failure of the MICN to meet established guidelines set by the Agency in maintaining current certification.

(1) The Agency's Office of Prehospital Certification shall advise Contractor in writing within twenty (20) calendar days of receipt of the notice of hiring as to whether the individual's certification is current.

(2) Failure of an MICN to meet current certification requirements established by the Agency and Agency mandated courses shall result in immediate suspension of his/her MICN certification.

R. Quality Improvement (QI): Contractor shall have a current prehospital care QI plan approved by the Agency and ensure participation in the Agency's systemwide QI program by designating a representative for the meetings.

Contractor shall have a process developed, with input from the Base Hospital Medical Director, base hospital physician, the PCC, MICNs, paramedics, and

Contractor administration to:

(1) Identify important aspects of prehospital care issues.

(2) Identify indicators for those important aspects.

(3) Evaluate the prehospital care and service, including trends, to identify opportunities for improvement.

(4) Take action to improve care and service, or to solve problems, and evaluate the effectiveness of those actions.

S. Paramedic Communications System (PCS):

(1) Provide the specific PCS Base Hospital Communications Equipment, Attachment "F-6", attached hereto and incorporated herein by reference, meeting the operational requirements and standards as determined by the Director of the ISD. Any changes in required communications equipment shall be mutually agreed upon between the parties. These changes shall be made in consultation with the Agency's PCS manager.

(2) Acquire and maintain in effect throughout the term of this Agreement FCC licenses for such communications equipment in accordance with

California Public Safety Radio Association ("CPSRA") procedures.

(3) Operate, maintain, and repair Contractor-owned PCS equipment in accordance with standards promulgated hereunder.

(4) Obtain leased lines to current or new remote control stations or to a closer termination point on new or current stations or lines jointly determined by Contractor, Director, and ISD, if Contractor is afforded capability of remote control radio stations located at a County site or other remotely located site. If the remote radio stations are located at a non-County site and are owned by Contractor, then Contractor shall also pay for all costs associated with the maintenance and repair of such stations, and for all costs of the A.C. power required for operating the equipment.

(5) Comply with the Communication Equipment Maintenance Standards, Attachment "F-7", attached hereto and incorporated herein by reference. Contractor further agrees to operate its PCS equipment in accordance with the transmitter power

output and antenna specifications as previously defined in Attachment "F-6".

(6) Comply with channel assignments made by Agency for communication with paramedics.

(7) Provide training of Contractor personnel assigned to Contractor's PCS operation on the use of communications equipment previously listed in Attachment "F-6".

(8) Have the capability of emergency maintenance and repair of PCS equipment, as well as periodic preventive maintenance, either by its own personnel or through a communications service company which has a service contract with Contractor and which has a demonstrated capability of providing the required services.

TRAUMA CENTER SERVICE AGREEMENT

Attachment F-1

COMMUNICATIONS MANAGEMENT COMMITTEE

1. PURPOSE: The Communications Management Committee ("CMC") is organized to provide technical and administrative assistance in the design, maintenance, and operation of the PCS to the PCS Manager.
2. ORGANIZATION: The CMC shall be composed of the following representatives or their designees:
   a. PCS Manager, appointed by the Director of the Department of Health Services;
   b. Chief Deputy Director, Internal Services Department;
   c. Executive Director, Healthcare Association of Southern California;
   d. Consultant, nominated by the EMSC;
   e. Representative, nominated by the Los Angeles County Ambulance Association;
   f. Representative, nominated by the Los Angeles County Chapter of the Southern California Fire Chief Association.
   g. Representative, nominated by the Base Hospital Advisory Committee.
   h. Failure of the listed non-County agencies to appoint representatives to the CMC shall not invalidate the formation of the CMC.
   i. Alternative arrangements which fulfill the purposes of this committee may also be utilized with the approval of the local EMS Agency.
3. RESPONSIBILITIES:
   a. Assess current operations of PCS;
   b. Identify current and on-going problems;
   c. Develop solutions and schedules for resolving problems;
   d. Report status to participants of PCS on a regular basis; and
   e. Bring major problems to the attention of the directors of the local EMS Agency and the Internal Services Department.
4. MEETINGS: The CMC shall meet on an "as needed" basis as determined by the PCS Manager.

BASE HOSPITAL FORM

Log # _____ SEQ. # _____ ATTACHMENT F-2

GENERAL INFO

Date ____/____/____ Prov. Code ____ Pt. # _____ of _____ Hospital Code Page 1

Time ____:____ Unit _____ Age _____ Sex: ☐ M ☐ F ☐ Radio ☐ Phone ☐ Info Only

Location _____ Weight _____ Kg / lbs. Peds Weight Color Code ☐ HEAR Radio ☐ SFT Protocol

☐ DNR ☐ Joint Run

ASSESSMENT

Chief Complaint Code ____ ____ ____ **SEVERITY OF ILLNESS** ☐ None ☐ MilD ☐ Mod. ☐ Severe

Needle ☐ CRicothyrotomy ☐ THoracostomy

Protocol _____ _____ _____

P _____

Q _____

R _____

Medical HX _____ S _____

Medications _____ T _____

☐ Meds prior to BC: ☐ NKA Allergies: ☐ Suspected Drugs/ETOH

PHYSICAL

LOC

CONSCIOUS
☐ Alert ☐ Oriented x 4
☐ Not Alert ☐ Disoriented
☐ Combative ☐ NorMal for Pt.

UNCONSCIOUS
☐ Responds to Verbal

Response to Pain
☐ Purposeful
☐ Nonpurposeful
☐ No Response

PUPILS
☐ PERL
☐ Unequal
☐ PInpoint
☐ Fixed & Dil
_____

GCS
Eye ____
Motor ____
Verbal ____

BREATHING
☐ Normal ☐ Clear
T.V. ☐ ↓ ☐ N ☐ ↑
☐ Apnea Episodes
☐ Wheezes
☐ Rales ☐ Unequal
☐ RHonchi ☐ JVD
☐ Stridor
☐ BS after ET/ETC
☐ CO_2 Detect. + −
☐ Other _____

SKIN
☐ Normal
☐ Hot
☐ CooL
☐ Pale
☐ Diaphoretic
☐ Cyanotic
☐ Flushed
☐ Jaundiced
☐ Other _____

EKG
Initial EKG
☐ VF ____
☐ PEA
☐ Asystole
_____
Prior to Contact
☐ CPR
Defib. x _____
at _____ Joules
at _____ Joules
at _____ Joules

TREATMENTS

☐ ≤6 yrs. B/P < 70 ☐ ≥7 yrs. B/P < 90 O_2 _____ L/Min. via ☐ NC ☐ Mask ☐ BVM ☐ BloW by ☐ ETC ☐ ET

☐ Spinal Immobilization ☐ Clear by algorithm

IV ☐ None ☐ TKO ☐ WO ☐ SL ☐ FC _____ cc ☐ I.V. Unobtain. Meds Ordered ☐ Yes ☐ No

☐ Chem Strip ☐ Glucometer _____

Time	B/P	P	R	O_2Sat	Drugs/Dose/EKG/Treatments	Results
					_____ Minutes to CPR	

CPR

Pronounced Rhythm _____ Pulses ¢ CPR ☐ Yes ☐ No CPR by: ☐ EMS ☐ Citizen ☐ None

Minutes from EMS CPR to Pronounce _____ Restoration of Pulse ☐ Yes ☐ No Witnessed by: ☐ EMS ☐ Citizen ☐ None

TRAUMA

☐ No Apparent Injuries ☐ BUrns/Shock ☐ Spinal Cord Inj.
☐ Inpatient Trauma

B	P		B	P		B	P	
☐	☐	Minor Lac/ Flail Chest	☐	☐	Head	☐	☐	Abdomen
					GCS ≤14			Diffuse Tend
☐	☐	T. Pneumo	☐	☐	Facial/Dental	☐	☐	Genital/ButtocKs
☐	☐	Trauma Arrest	☐	☐	Neck	☐	☐	Extremities
			☐	☐	Chest			FRactures
☐	☐	Back			Bet Mid Clav			Amputations

MECH OF INJ

☐ Enc Veh. ☐ Seat Belt ☐ Air Bag ☐ Assault ☐ Fall ____ Chief M.O.I.
☐ Pass Space Intrusion ☐ With Blunt Instr ☐ >15 ft
☐ Surv. of Fatal Acc. ☐ STabbing ☐ Electric Shock
☐ EJected from Vehicle ☐ GSW ☐ Hazmat Expos.
☐ EXtrication Required ☐ TRunk ☐ Thermal Burn
☐ Ped/Bike vs Vehicle ☐ SI Accidental ☐ SPorts
☐ Motorcycle/Moped ☐ SI Intentional ☐ Wk Related
☐ Vs Vehicle ☐ ANimal Bite ☐ UNknown
☐ HeLmet ☐ OTher _____ ☐ CRush

TRANSPORT

Check One Box & Indicate Codes & ETA's on all Transport Options

Transported To:	CODE	ETA
☐ MAR		
☐ Desig. TC		
☐ PCCC		
☐ EDAP		
☐ PERINATAL		
☐ Other		

Rationale for Trans. to Other
☐ ED SAT
☐ Int. Disaster
☐ Trauma Center
☐ Peds (PCCC)
☐ CT
☐ Neuro
☐ Request by _____
☐ Other _____

VIA
☐ ALS
☐ BLS
☐ Heli ETA _____
☐ Police
☐ Other _____

NO TRANS
Not Transported
☐ AMA ☐ DOA
☐ Unwarranted
☐ Pronounced _____ Time
☐ Other

TRAUMA/PEDS

Transported to T.C./PCCC because:
☐ Meets TC/PCCC criteria
Does not meet TC/PCCC criteria....however:
☐ TC Guidelines
☐ Shared Ambulance ☐ B.H. Judgement
☐ Other _____ ☐ Req: Pt/Fam/PMD/Other

NOT transported to TC/PCCC because:
☐ Does Not meet TC/PCCC criteria
Meets TC criteria....however:
☐ Cardiac Arrest ☐ Hemorrhage ☐ AirWay
☐ Min.Injuries ☐ ETA>20 min.
☐ Diversion ☐ Req: Pt/Fam/PMD/Other
☐ No Desig. TC/PCCC ☐ Other _____

DISPO

Time Clear ____:____

Time Receiving Hosp. Notified ____:____

Person Notified _____

If Base is = Receiving hospital: ☐ Ward ☐ OB ☐ Expired ☐ Discharged

Adm. to Rm # _____ ☐ ICU/CCU ☐ OR ☐ Stepdown ☐ Other _____

Transferred from E.D. to _____ HOSP. CODE

E.D. Diagnosis _____

COMM SIG

MICN/Cert. # _____ Physician _____ Patient Name/Number _____

BASE HOSPITAL FORM
(Page 2)

ATTACHMENT F-2
Page 2

Log # _____ Seq. # _____

Date | | | | | | | Hospital Code | | | |

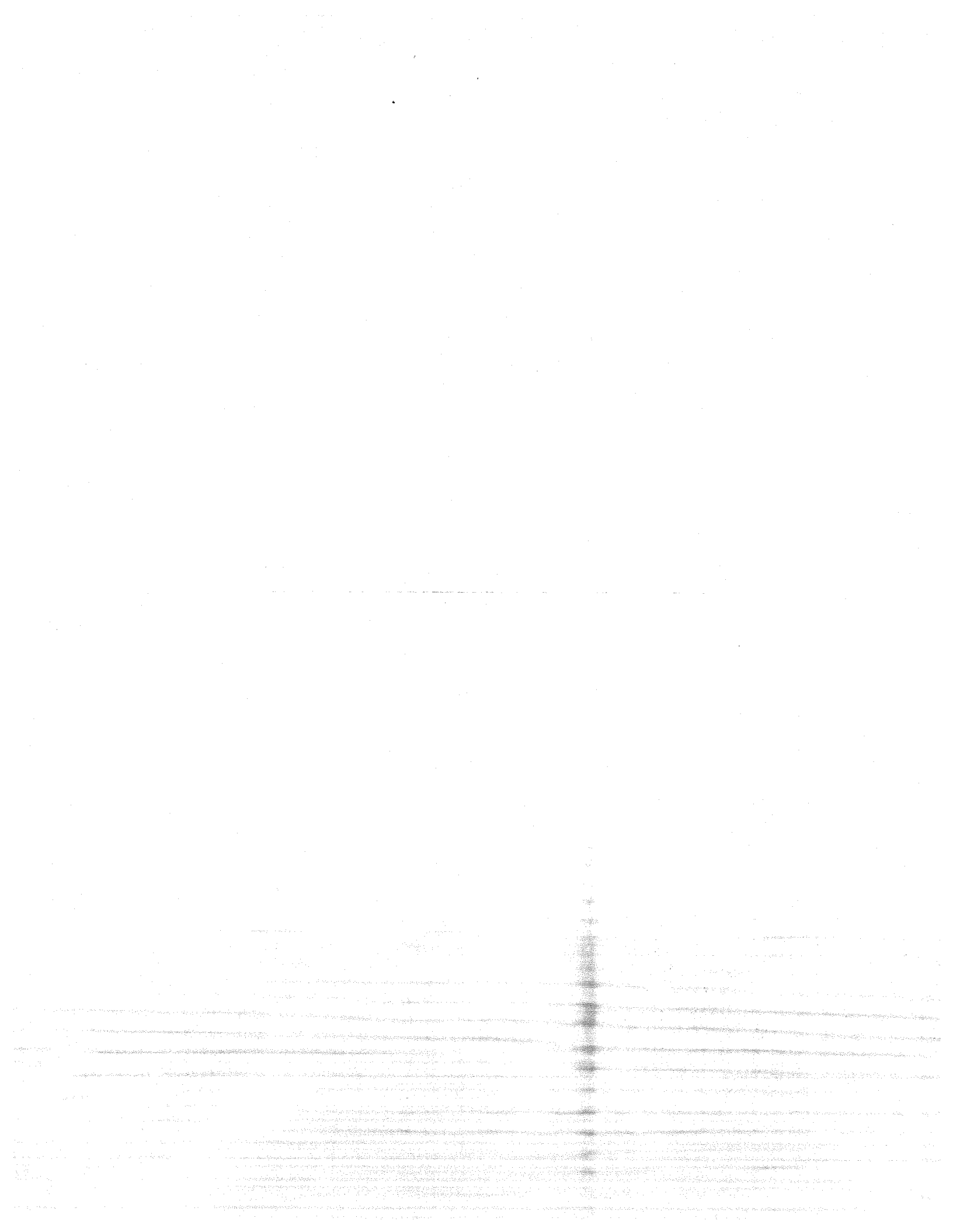
Time	B/P	P	R	Drugs / EKG / Treatments	Dose	Results

Additional Comments:

SIGN	MICN/Cert. #	Physician	Patient Name/Number

H2364 76B15H2

(Must accompany Page 1)



TRAUMA CENTER SERVICE AGREEMENT

Attachment F-3

RECEIVING HOSPITAL OUTCOME DATA

The following data elements are to be entered on to the Base Hospital Form and into the County's automated data collection system (TEMIS), for all patients where Hospital provided base hospital medical direction to prehospital care personnel and patient was delivered to its emergency department via the County's prehospital care system:

Admitted to: Rm# _____

- ☐ Ward
- ☐ OB
- ☐ ICU/CCU
- ☐ OR
- ☐ Stepdown
- ☐ Other _____

☐ Expired

☐ Discharged

Transferred from ED to _____ | | | | |
Hosp Code

ED Diagnosis _____ | | | | | | |
ICD-9 Code

TRAUMA CENTER SERVICE AGREEMENT

Attachment F-4

TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS

DESCRIPTION	TOTAL QUANTITY
Dell Optiplex GX110 600 MHZ P-III	1
Mid-size Desktop Chassis	1
10/00 Ethernet	1
256K Cache	1
10/20 GB Tape Drive	1
3 Com V90 56K Voice	1
48xCD ROM	1
Audio PCI 64 Voice	1
6.4 Gb EIDE Hard Drive	1
128MB Non-ECC SDRAM 1 DIMM	1
M770 17 inch Monitor	1
4MB Video	1
Space Saver Keyboard	1
Dell Mouse	1
HP LaserJet 2100XI	1
10PPM 4MB 1200DPI PAR IR EIO Slot	1
Windows Client 2000	1
Personal Oracle 8.X	1
PC Anywhere 9.X	1
Norton Antivirus 2000	1
LA Base 4.0	1

PARAMEDIC BASE HOSPITAL REQUIREMENTS

Attachment F-5

HOSPITAL EMPLOYEE ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT REGARDING BASE/TRAUMA HOSPITAL DATA COLLECTION OBLIGATION

HOSPITAL : _____

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work associated with my employer's base/trauma hospital data obligations. I agree to forward all requests of the release of any data or information received by me to my employer's TEMIS supervisor.

I agree to keep all hospital, patient, and/or agency identifiable TEMIS data confidential and (unless authorized by the patient or the appropriate agency/hospital CEO) to protect these confidential materials against disclosure to other than my employer or County authorized employees who have a need to know the information.

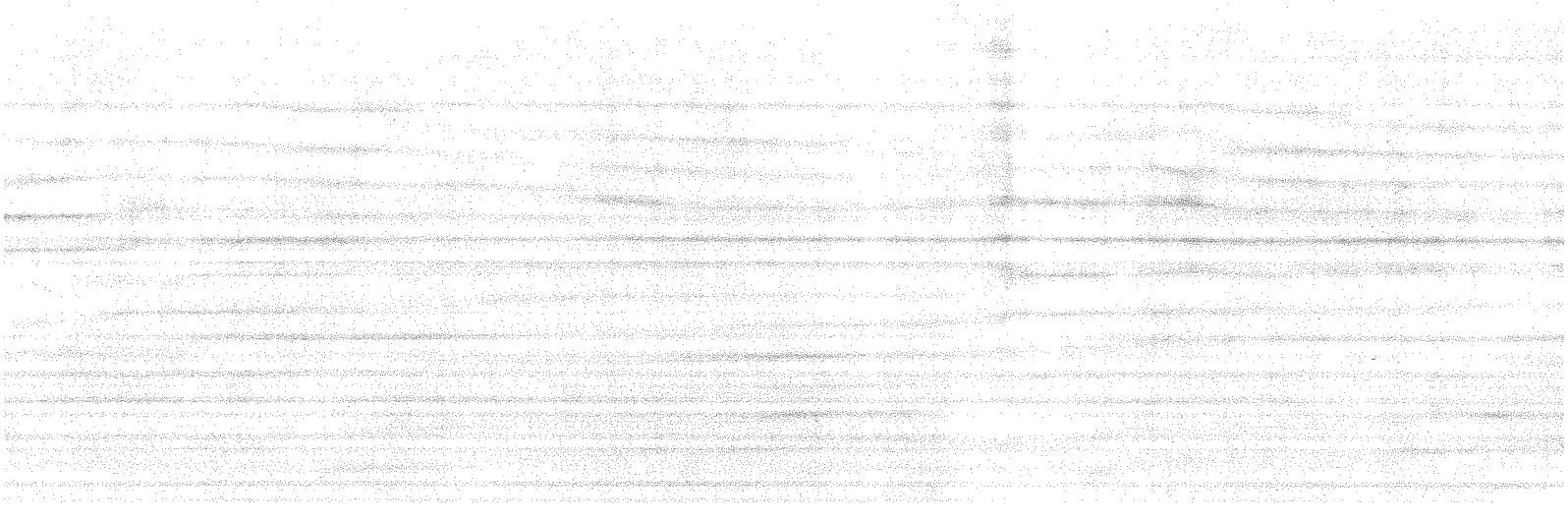
I agree that all TEMIS software application modules, and all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation, aids, and other items provided to hospital by County for the purposes of the Trauma and Emergency Medicine Information System (TEMIS) data collection shall be considered confidential. As such, I will refrain from reproducing, distributing, or disclosing any such confidential County products except as necessary to perform the Hospital's base/trauma hospital data collection obligation.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of which I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of my employer's data collection obligation or termination of my employment with my employer, whichever occurs first.

I acknowledge that violation of this agreement may subject me to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

NAME: _____ DATE: _____
(Signature)

POSITION: _____



TRAUMA CENTER SERVICE AGREEMENT

Attachment F-6

BASE HOSPITAL COMMUNICATIONS EQUIPMENT

The following list describes the minimum equipment requirements involved in the Hospital's portion of the Emergency Medical Service Communications System (EMSCS).

I. MED 1-8 RADIO STATIONS
   A. Radio Equipment
      1. 2 each - Transceiver, 4-channel, transmitter output adjustable between 20-45 watts, with CTCSS and "AND" squelch
      2. 2 - Duplexer
      3. 2 each - Antenna, Omni-directional, vertically polarized, typically 5.0 dB gain
      4. 2 each - Hardware Kit, Antenna Mounting
      5. 2 each - Coaxial cable, (5/8 hardline type) low-loss at UHF, including connectors, etc. (maximum length - approx. 100 ft.)
   B. Radio Transmitter Power - Power output of each MED 1-8 transmitter shall be adjusted for 20 watts to appear at the base of the antenna.

Base hospital agrees to upgrade EMSCS equipment as described in Radio Specifications 1927 and 1928 as revised by County of Los Angeles Internal Services, to meet the State Emergency Medical Services Authority EMSA. Future FCC mandates to operate on Digital Modes and Narrow Band Frequency standards, when adopted by public safety Radio Communications organizations, such as APCO, must be kept in mind if replacing e the State Emergency Medical Services Authority's EMSA Narrow Band Frequency Standard when adopted.

II. MED 9 RADIO STATION
   A. Radio Equipment
      (1) 1 each - Transceiver, Single-Channel, transmitter output adjustable between 20-45 watts, with CTCSS and "AND" squelch.
      (2) 1 each - Duplexer
      (3) 1 each - Coaxial cables (5/8 hardline type) low-loss at UHF, including connectors, etc. (maximum length - approx. 100 ft.)
      (4) 1 each Antenna, Omni-directional, vertically polarized, typically 5.0 dB gain.
      (5) 1 lot Hardware Kit, Antenna Mounting.
   B. Radio Transmitter Power
      Power output of the MED 9 transmitter shall be adjusted

for 20 watts to appear at base of antenna.

Base hospital agrees to upgrade Paramedic Communication system (PCS) equipment as described in Radio Specifications 1927 and 1928 to meet the State Emergency Medical Services Authority's EMSA Narrow Band Frequency Standard when adopted.

TRAUMA CENTER SERVICE AGREEMENT

Attachment F-7

COMMUNICATIONS EQUIPMENT MAINTENANCE STANDARDS

I. Radio station room, antenna structure and control lines

A. Radio Station Room

1. Radio equipment shelter (with sufficient space to install three (3) radio stations). (Not required if the Hospital has suitable existing facility to house radio station equipment on roof or top floor of Hospital's tallest building.
2. 1 each Power Distribution Panel (wired to hospital's emergency A.C. power as well as commercial power)
3. 5 each A.C. Power Outlets near radio stations and connected to Item No. 2 above .
4. 1 lot - Hardware Kit, Antenna Mounting

B. Antenna Structure

1. 1 each Tower, antenna, up to 60 ft. or other structure suitable for antenna mounting (installed near radio station room)

C. Radio Control Lines

At least four (4) sets of 4 wire circuits (one set per transceiver and one spare set must be installed by hospital from terminal block(s) in the radio station room termination points close to the control consoles.

D. Control Consoles and Paramedic Telephones

1. Location in the Emergency Department
2. Console Equipment
   a. 1 each - Hospital Coordination Console (HCC) per Specification No. 1928, or other suitable tone/remote control console with DTMF decoder
   b. 2 each - Medical Communications Console per Revised. Specification No. 1927

Above item can be a single equipment instead of two, if provision is made for control of both MED 1-8 transceivers from the single console. Provision must also be made for connection of both paramedic emergency telephones to the single console. The Console must provide means to log all traffic via radio channels and telephone calls to the console. The recording medium must be of archival quality. It is recommended that, unless space considerations for the consoles are the Hospital's primary concern, two MCTC's be installed.

II. Power Outlets

At least 8 A.C. power outlet shall be provided. Outlets must be connected to Hospital's emergency power system as

well as commercial power.

III. Paramedic Emergency Telephones
Two telephones with telephone lines shall be dedicated for paramedic/hospital communications.

IV. Maintenance and Trouble Call Reporting
A. Purpose: To provide preventive and ongoing maintenance and/or repair for PCS Equipment.
B. Responsibilities of Hospital:
1. Provide the local EMS Agency with evidence of 24 hours per day, 7 days per week maintenance and repair service for radio and system equipment.
2. Report problems to the Internal Services Department.
3. Perform or cause to be performed the following preventive maintenance:
a. Quarterly: Systems check to include:
(1) console functions and operation;
(2) transmit and receive test of all frequencies.
(3) Clean and service base hospital console tape deck.
(4) Confirm operational performance of all EKG related equipment.
b. Annually:
(1) FCC frequency and deviation test for all radios;
(2) Visual inspection of the antenna structures;
(3) Solicit report from assigned field provider units about any chronic communication problems to include but not be limited to field equipment, dead space, radio failure and co-channel interference, and submit a written report to the local EMS Agency about such problems.